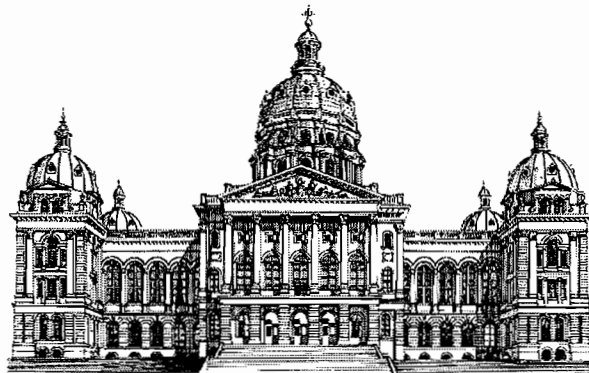


REPORT

LEGISLATIVE COMMISSION
ON
AFFORDABLE HEALTH CARE PLANS
FOR
SMALL BUSINESSES AND FAMILIES



Presented to the
LEGISLATIVE COUNCIL
and the
IOWA GENERAL ASSEMBLY
January 2008

Prepared by the
LEGISLATIVE SERVICES AGENCY



January 2008

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On behalf of the Legislative Commission on Affordable Health Care Plans for Small Businesses and Families, we respectfully submit the attached report for consideration.

This was no ordinary interim committee. We have met monthly since June 2007. A highly qualified staff member from the National Conference of State Legislatures facilitated the monthly meetings. Three public hearings were convened by former Governors Terry E. Branstad and Thomas J. Vilsack. The Commission broke into topical workgroups according to interest, information, and expertise. These workgroups met numerous times, and their work became the basis for detailed recommendations.

The Commission met in six separate cities in Iowa and meetings were conducted with transparency. Not one meeting had less than 27 out of 29 Commission members in attendance, and the effort by the public and appointed members was extraordinary. We believe that every constituency had the opportunity to be heard by the Commissioners.

Nine percent, approximately 270,000, of Iowans are without health care coverage. The task of the Commission was to develop a method to close this disparity in a way that is affordable for businesses and families. The report documents the strengths and weaknesses of the current system. Most importantly, the report outlines a path for Iowa leaders to follow that will establish a better system of delivering affordable health care to Iowans and ensure that Iowans become healthier and stay well.

The Commission unanimously called for universal or near universal coverage, and we have outlined a plan for Iowa to reach this goal. We recognize that states cannot do this alone, but waiting for the federal government to act would be fruitless; the constituents no longer have the patience. As a result, the Commission believes that Iowa should lead the way. And we believe it can be done.



REPORT

Legislative Commission on Affordable Health Care Plans for Small Businesses and Families

January 2008

APPROVED BY THE COMMISSION

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Senator Jerry Behn
Senator Joe Bolkcom
Senator Larry McKibben
Senator Amanda Ragan

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Representative Mark Smith
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Mr. Jay Christensen
Ms. Amy DeBruin
Dr. Steven Fuller
Ms. Barb Kniff

Consumers:

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Ms. Sarah Swisher
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AUTHORIZATION AND APPOINTMENT

The Legislative Commission on Affordable Health Care Plans for Small Businesses and Families (2007 Iowa Acts, chapter 218, section 99, 127, and 128). The Commission was created by the legislation and directed to:

1. Review, analyze, and make recommendations on issues relating to the affordability of health care for Iowans.
2. Include in its final report a summary of the Commission's activities, an analysis of the issues studied, and recommendations for legislative reforms that would make health insurance coverage more affordable for small businesses and families in this state, and any other information that the Commission deemed relevant and necessary.

The legislation also created the Health Care Data Research Advisory Council to assist the Commission with research, analysis, and other functions, and appropriated \$500,000 for FY 2008 to the Legislative Services Agency to support the work of the Commission and council. To accomplish the charge of the Commission, the Legislative Council authorized the Commission to procure consultation and other support directly through the advisory council or through exclusive contracts with other entities able to perform in the short time frame provided for the study, subject to legislative expenditure guidelines.



Legislative Commission on Affordable Health Care Plans for Small Businesses and Families

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I. The Background

A. Establishment of Commission

Charge. The Legislative Commission on Affordable Health Care Plans for Small Businesses and Families was created by 2007 Iowa Acts, chapter 218, section 127 (Attachment I, Legislation). The Commission was charged to:

“review, analyze, and make recommendations on issues relating to the affordability of health care for Iowans including but not limited to:

a. The benefits and costs of requiring all residents of Iowa to have health insurance coverage, including but not limited to individual mandates and proposals from other states.

b. The benefits and costs of providing health insurance coverage to all children in the state, with a particular emphasis on children's health issues.

c. Uninsured and underinsured Iowans with a special focus on determining the characteristics of the uninsured and underinsured populations, why such persons are uninsured or underinsured, and the most effective and efficient means to provide insurance coverage to such persons, including through government programs.

d. Major factors and trends that are likely to impact the cost of premiums and affordability of health care during the next ten years, including but not limited to effects of mandates, levels of coverage, costs and pricing of treatments, cost-sharing and cost-cutting measures, cost-shifting measures, collaborative opportunities, subsidies, reinsurance plans, risk pooling, and wellness and disease prevention initiatives.”

Membership Specified. The legislation directed that the membership of the Commission include ten members of the General Assembly; members of the public appointed by the Legislative Council from designees of representative organizations of small business owners, hospital administrators, health care providers, insurance agents, and insurance carriers; five consumers appointed by the Governor; and state agency heads as appropriate. (Attachment II, Membership)

Health Care Data Research Advisory Council. The legislation also established a Health Care Data Research Advisory Council to assist the Commission in carrying out the Commission's duties by conducting research, providing research data and analysis, and performing other functions within the expertise of the members of the council at the direction of the Commission. (Attachment III, Legislation, Attachment IV, Advisory Council Membership, Attachment V, Summary of Advisory Council Activities, Attachment VI, Health Policy Brief — Health Insurance and the Uninsured in Iowa)



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Final Report. The legislation directed the Commission to complete its deliberations in December 2007, and submit a final report to the General Assembly for consideration during the 2008 Legislative Session summarizing the Commission's activities, analyzing issues studied, making recommendations for legislative reforms that will make health insurance coverage more affordable for small businesses and families in this state, and include any other information that the Commission deems relevant and necessary.

Appropriation. 2007 Iowa Acts, chapter 218, section 99, provided an appropriation of up to \$500,000 for carrying out the duties of the Commission and the advisory council. (Attachment VII, Appropriation)

Number of Meetings. The Legislative Council approved eight regular meetings of the Commission with an additional three public hearings.

B. Commission Meetings

The Commission held eight regular meetings including a special meeting to receive reports and recommendations from the public hearings and three public hearings. The regular meetings were held on June 20, 2007, in Des Moines; July 18, 2007, in Oskaloosa; August 15, 2007, in Mason City; September 19, 2007, in Iowa City; October 10, 2007 (special meeting), in Des Moines; October 17, 2007, in Sioux City; November 14, 2007, in Dubuque; December 19, 2007, in Des Moines; and January 8, 2008, in Des Moines. (Minutes of each meeting may be found at: www.legis.state.ia.us/scripts/docmgr/docmgr_comdocs.dll/showtypeinterim?id=true&type=ih&com=208)

Briefings of the meetings may be found at:

www.legis.state.ia.us/lsadocs/BriefOnMeetings/2008/BMAMV000.PDF

C. The Commission Process

The Commission's composition allowed for participation of many stakeholders involved in the health care system. Commission members realized the gravity, complexity, and contentiousness of the issues, and the nature of each stakeholder, historically, to have a unique, fixed perspective in health care deliberations. Because of this, the Commission utilized a facilitator from the National Conference of State Legislatures to work through difficult topics and divided into workgroups to work toward consensus on various issues. Workgroups covered the following topics:

- Workforce Shortages — Work group #1
- Electronic Health Records — Work group #2
- Medical Home — Work group #3
- Health Care Coverage — Work group #4
- Iowa Health and Wellness Strategies — Work group #5
- Patient's Rights/Cost Containment/Funding — Work group #6

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(Attachment VIII, Mr. Bruce Feustel, Background, Attachment IX, Work group Reports, Attachment X, Commission Staff)

The collaborative process, as much as the results of the process, provide a strong basis for continuing work as the recommendations are considered by the General Assembly and the public.

D. Commission Survey of the Public

The Commission established a link on its web site for members of the public to post responses to health care-related questions. There were three questions posed:

1. What do you like or not like about Iowa's health care system and plans?
2. Please tell us about a successful wellness/prevention effort in your workplace/school/community.
3. What are your ideas for reducing costs in the health care system?

The complete list of the questions and responses may be accessed at:

www.legis.state.ia.us/asp/Survey/Responses/.

The following is a sample of responses from everyday Iowans who responded to the question: **“What do you like or not like about Iowa's health care system and plans?”** (Edited for spelling errors only)

8/4/2007 10:06:26 PM

I am near 60. Both myself and my wife have considerable health problems. We have received excellent care from University of Iowa. The problem now is paying for it. Our monthly health care costs are running at \$2,000.00 per month. We have exhausted our savings and have no hope for retirement. Hopefully we can reach Medicare age and receive some relief. I just don't know what we are going to do.

8/9/2007 9:28:59 AM

The cost to purchase health insurance. I can not afford the coverage my family needs.

8/13/2007 10:23:53 PM

There is simply no affordable way for a self-employed person to obtain health care for his/her family. Insurance for self-employed individuals is exceptionally expensive, particularly with pre-existing conditions. I feel lack of affordable health care options seriously factors into the decision making of many would-be entrepreneurs.

8/17/2007 4:48:52 PM

I am thankful for HIPIOWA, because without it I'm not sure what I'd do! I would like to see MENTAL ILLNESS covered just like cardiovascular, diabetic... diseases are. With cardiovascular the organ



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affected is the heart; with mental illness the organ affected is the brain. I can tell you from personal experience that a serious concern for those afflicted with a mental illness is figuring out how to pay for the services, therapy, and medications. A huge stressor comes into play when the illness is chronic, and disables the person to the point of not being able to work. Cobra only lasts so long. The cost becomes a huge burden for mentally ill who is no longer able to work. Social Security Disability Benefits takes around 2 years before any money is provided. I was lucky enough to have enough equity in my home to get a loan to pay for my health insurance, medical bills, house payments, utilities, and raising 2 children alone.

8/18/2007 12:09:45 PM

It seems the middle working class or self-employed still loses out. I make just enough to be over the poverty level yet I am not covered by insurance unless I wish to pay around \$1,000 a month (and increasing yearly) for family coverage (two adults). I think you need to allow pools of self-employed people to form so we can have much better rates and a choice of deductibles. Sure you are making it better for child insurance coverage and low income people. But (hopefully) the children will grow up to be working adults and the low income people will move up to...guess what? Middle working class. Either fix the medical expense by limiting liability lawsuits payouts or go to work on the insurance companies that do not offer group plans to self-employed workers. Thank you.

8/20/2007 7:04:30 AM

I do not like that when I switched from group insurance to individual policy, I had three (3) riders put on and it is from the SAME insurance company. Why? So what is the sense of having insurance when it does not cover preexisting conditions from the SAME insurance carrier? I retired from the company I worked for 29 years and went full time self employed. So it did not cover existing meds that I take already and now cannot because it COST too much. I am talking from \$30 to now \$195. Thank you for your time in this matter.

8/20/2007 8:20:26 AM

The quality of Iowa's health care system is excellent. However, only those with excellent health insurance plans can afford it. The working poor and single adults with no children who do not qualify for State assistance but who also do not have enough money to pay for insurance are left with nothing. Someone might say: What about Iowa Care? Well, unless you live in Polk Co., it can be difficult to access because you have to go to Iowa City. This makes it difficult for those living far away. Also, the health care system in Iowa is fragmented. Supposedly, there are free health clinics but how do you find out where they are? Are they in every county? Plus, substance abuse treatment and mental health treatment are often hard to access. I have a son who is a drug addict and an alcoholic who suffers from PTSD and is now cutting and burning himself. He tried to access mental health services but was told that since his legal settlement is in another county they cannot help him. There should be some coordination between counties so that people who desperately need help can get it.

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8/20/2007 10:59:44 AM

We need to pursue National Health Insurance so that everyone can contribute toward a good program but yet everyone has health insurance coverage. We all pay extra for the non-covered individuals seeking medical care and state Title 19 patient's care. Iowa has way too many Title 19 programs - poor people need to contribute to their health care just as working people. A person should not have to fear changing jobs, having good health insurance previous but fear that the next health insurance provider will have lesser benefits or put a rider on existing medical conditions if in a smaller insurance plan. There are many persons who get a job, may be offered health insurance, but can't afford (or do not prioritize) to pay the per month premiums (if their employer does not provide this benefit 100%) so they go without insurance. Also people who may want to retire early (57-62) from a job can not afford the private pay \$500/\$1000 mo. to keep their health insurance in force and also worry whether appropriate coverage would be there. This would open up a lot of jobs in Iowa if these people could retire w/affordable premiums for health insurance.

8/21/2007 6:32:38 AM

Plans now are able to exclude persons from obtaining coverage based on pre-existing conditions. I am a cancer survivor and have tried to obtain coverage but when I tell insurance agents that I had cancer, they say "sorry, can't write a policy for you ---call me in 5 years." I know the state has a universal policy now that covers persons in this situation but it is not widely know or marketed to the public. The plans also are not very good in my opinion because you must take a very high deductible in order to make the monthly premiums affordable. High deductibles are just like have no insurance at all. Thank you.

8/20/2007 12:25:48 PM

I have found it increasingly difficult to navigate the health care system for my family due to increased specialization of doctors and the lack of centralized and coordinated electronic communication between doctors offices. Such communication should be available in order to make the transfer of necessary patient information available at the click of a mouse. Also, I believe Iowa needs to expand the availability of and access to quality mental health care and expand mental health parity so that these services can be paid for through all types of insurance programs. Universal Health care services need to be available to ALL lowans (including dental and eye care) and until we achieve that, the job isn't done.

8/20/2007 4:00:57 PM

All children in Iowa need to be covered in a state wide health plan. Many fall through the cracks as parents might be above the poverty level but still cannot afford health insurance offered by their employer. While there are no quick answers for this problem can we find a solution? We have to find one. Thank you, Ann Tornabane



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8/22/2007 8:05:10 PM

The uninsured/underinsured should be allowed to form a group of their own to enable everyone to have coverage at affordable rates similar to a large company. Something needs to be done for single people with no children who don't qualify for Medicaid.

8/31/2007 12:38:16 PM

It would be very cool if Iowa could again take a leading role in the nation by showing that all its citizens could have access to healthcare...like the rest of the civilized world BESIDES the USA already has. It's time to stop kidding ourselves and get REAL about healthcare in this country, and as a proud Iowan, I love the idea of taking charge and showing the rest of the country what can be done when citizen care enough about each other to offer them a healthy life. Iowa's a great place to live...and it can be even greater!

8/31/2007 4:14:25 PM

Iowa's health care system still does not do much to help caregivers of elderly parents/relatives. Increased personal income of baby boomer aged children is being spent on their parents' health care to prevent their going into nursing homes. When will the state help us with tax credits or refunds like child care? We go from paying for our children's care right into paying for our parents. We are going bankrupt and cannot save for our own financial needs. Lora

9/4/2007 1:50:12 PM

I am a type 1 diabetic and a self employed contractor. I am a therapist with a private practice. This requires that I purchase my own health care. My practice is too small to purchase a health care benefit. The only insurance company that will cover me is Midland Choice through HIPIOWA. This gives me the privilege of spending close to \$6,000 per year on premiums with a \$2,500.00 deductible. Most lab charges are not covered and I was told that a follow up mammogram was not "medically necessary" so that was not paid for either. I avoid using my "health insurance" as much as possible. I am horrified by the idea of ever having to be hospitalized with my 80/20 plan. I have made a decision to leave my private practice and join an agency for health care. My health care is not affordable and I am punished for being diabetic. I was 48 yrs. old when diagnosed with type 1. I am a non-smoker and I exercise and watch my diet but with a chronic illness I am discriminated against by the health insurance industry.

9/5/2007 10:23:56 AM

As a self-employed Iowan, affordable health insurance is a challenge to find, but not impossible. My Health Savings Account through United Health Care has been a life-saver.

9/5/2007 11:49:36 AM

After taking care of my aging parents for 20 plus years and currently taking care of my ninety year old mother, it has been evidenced by me, as well as different ones in the health care profession,



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that our expensive health care system has degenerated to record keeping, billing, and a stab at public relations with very little common sense health care provided

9/5/2007 12:56:46 PM

One serious problem that is not addressed is when kids have a preexisting condition and become young adults. They have a hard time getting a job because no employer wants their health costs to go up and they can not get health insurance.

E. Public Hearings Co-hosted by Former Governors Terry E. Branstad and Thomas J. Vilsack

The public hearings were co-hosted by former Governors Branstad and Vilsack and were held on September 4, 2007, in Council Bluffs; September 26, 2007, in Indianola; and September 27, 2007, in Bettendorf. A special meeting of the Commission was held on October 10, 2007, in Des Moines, to receive reports and recommendations provided by former Governors Branstad and Vilsack.

Former Governor Branstad's Report and Recommendations. Former Governor Branstad noted that as the current President of Des Moines University he is particularly interested in health issues and how we educate future generations of providers, how we study and research health and prevention issues, and how we create effective personal programs and interventions that impact health behavior in a positive way. Former Governor Branstad stated that issues of health plans and health care must be addressed now for the following reasons:

- Iowa Medicaid and the IowaCare Program have grown to serve more individuals over the past five years and together are the fastest growing area of the state budget, impacting all other spending priorities.
- Health care costs are an issue affecting everyone: individuals, businesses, organized labor, and government as health care costs rise at rates exceeding income and as sickness impacts worker productivity.
- Health care is good in Iowa, but the health status of Iowans deserves attention with promotion of better prevention and improved health status.
- Iowans believe in prevention and wellness but our health system focuses on "sick care" instead of "well care."

Former Governor Branstad then recommended five action themes for consideration by the Commission:

1. **Move Toward Health Care Coverage for All Iowans.** Develop a thoughtful approach with technical leadership and involvement by all stakeholders to expand coverage to more Iowans.
2. **Restructure Health Plans.** Iowa is recognized for its quality health care, but Iowans should demand that health plans shift their focus to supporting prevention and



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wellness. Iowa needs to address its ranking in the bottom half of the United States based on prevalence of cardiovascular disease, asthma, diabetes, cancer, and obesity and overweight conditions.

3. **Focus on Chronic Conditions.** The greatest costs in health care revolve around chronic disease, particularly in Iowa where there is a higher percentage of mature individuals. Iowa should embrace efforts to conduct health status and health risk assessments to educate its citizens about healthy behaviors, managing risks, and the availability of treatments.
4. **Provide Incentives to Do the Right Thing.** Good health behaviors should be encouraged, particularly in prevention and wellness initiatives, by coverage of prevention services with low or no co-pays and deductibles, reduction of premiums for healthy actions and behaviors, creation of healthy workplaces, and other incentives by employers and organized labor to encourage healthy behaviors. Iowa Medicaid needs to be as serious about prevention and wellness as it is about treatment of illness and communities need to promote prevention and wellness.
5. **Quality, Patient Safety, and Transparency.** Creation of a better health care climate in Iowa requires actions to aggressively promote quality, patient safety, and transparency. Information about Iowa health care providers' quality and patient safety performance, price, and other information is essential to achieve this. The General Assembly should consider adopting the Four Cornerstones of Value-driven Health Care espoused by the federal Department of Health and Human Services (interoperable health information, transparency of quality information, transparency of price information, and use of incentives to promote high-quality and cost-effective care); promoting the National Quality Forum Safe Practices to Support Patient Safety; and promoting transparency efforts like voluntary reporting on health care-associated infections being led by the Iowa Healthcare Collaborative.

Former Governor Vilsack's Report and Recommendations. Former Governor Vilsack thanked the General Assembly and the co-chairpersons, former Governor Branstad, Commission members, and staff for their work on such a complex and significant issue. Former Governor Vilsack particularly thanked all the Iowans who shared their stories at the public hearings and offered solutions. He cited Dr. John Kitzhaber, former Governor of Oregon and a medical doctor, who called for a clear vision and a focus comparing that vision with the contradictions in the current health system to create the tension that leads to change. Former Governor Vilsack stressed that there are moral, economic, and competitive reasons to reform Iowa's health care system. Former Governor Vilsack stated that the vision for such reform should encompass the following principles:

1. **Be Patient-centered and Consumer-centered.** Use consumer purchasing alliances that put the consumer/patient in control and center on quality, including reporting requirements that define what quality is and where it can be found.



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2. **Focus on Prevention and Wellness.** Provide incentives for the right health care behaviors and make an aggressive effort to encourage prevention and wellness through appropriate screening and tests; creation of medical and dental homes, especially for children; and the involvement of families, schools, and communities in prevention and wellness efforts.
3. **Make Health Care Coverage Available to All.** Universal coverage of all Iowans should be the goal. Iowa can move toward this goal by insuring all children, including an expansion of the IowaCare Program. Iowans should encourage national policymakers to commit to a national program of universal coverage and learn from the health care reform efforts of other states.
4. **Health Care Coverage Should be Fair to All.** Recognize that people of color in Iowa do not receive the same care that whites do. Health care must be universal in coverage and quality of care. Dental coverage is important.
5. **Provide the Right Care at the Right Time at the Right Place.** Iowa's goal should be to be number one in the country for health care. Encourage electronic recordkeeping to create a seamless system that can yield data to determine what treatments work. Focus on payment for performance not fee-for-service to achieve higher patient satisfaction, better results, and cost savings.

F. Lieutenant Governor's Commission on Wellness and Healthy Living

In summer 2007, Iowa's Lieutenant Governor Patty Judge created a five-person commission on Wellness and Healthy Living to gather new and innovative ideas from Iowans about wellness and healthy lifestyles. The commission held a series of 10 town hall meetings around the state and as a result issued a report in October 2007 which recommended five steps toward achieving a healthier Iowa: (1) removing unhealthy foods in schools by providing healthier school lunches and vending machine selections; (2) improving the health of Iowa's children by setting school physical activity requirements and encouraging student wellness, including well-child screenings; (3) encouraging more Iowans to quit smoking by allowing communities to pass local smoke-free ordinances and by expanding smoking cessation programs; (4) encouraging physical activity for seniors by working with the Department of Elder Affairs and the Department of Public Health to expand physical activity programs for seniors; and (5) promoting prevention efforts by encouraging Iowans to get regular health screenings, including mental, dental, cancer, and other preventive measures, and working with the Department of Public Health to assure access to such services, and create a wellness web site where Iowans can learn about successful wellness efforts across the state, create their own personal wellness plans, and receive information about healthy eating, physical activity, and health screenings. Lt. Governor Judge reported the findings and recommendations of the Commission on Wellness and Healthy Living at the November meeting of the Legislative Commission on Affordable Health Care Plans for Small Businesses and Families. (Lt. Governor's Commission on Wellness and Healthy Living documents may be found at: www.governor.iowa.gov/lt-governor/healthy-living.php)



Legislative Commission on Affordable Health Care Plans for Small Businesses and Families

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II. Iowa — The Current Picture — Close-Up

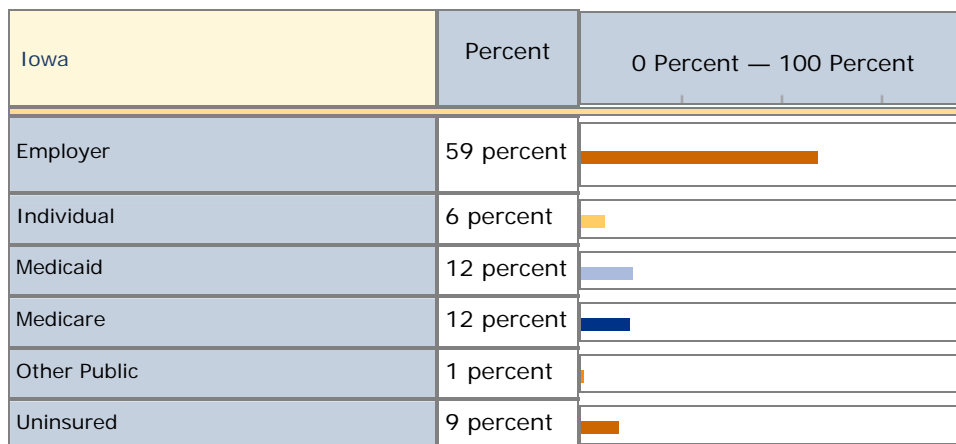
A. Positive Attributes of the Current System

Health System Performance. Iowa ranks second overall in the Commonwealth Fund State Scorecard on Health System Performance Indicators for 2007 which assesses state variations across the key dimensions of health system performance: access; quality; potentially avoidable hospital use and costs of care; equity; and healthy lives.¹

Low Rate of Uninsured. According to a 2005-2006 estimate, Iowa's population of almost three million (approximately 740,000 children 0 through 18 years of age, approximately 1.8 million adults 19-64 years of age, and approximately 383,000 adults 65 years of age and older) has one of the lowest rates among the states of total uninsured residents at approximately 9 percent, ranking third lowest in the nation behind Minnesota and Hawaii.²

Iowa's Insured. The majority of Iowa's population has health care coverage which is mainly employer-sponsored coverage. Coverage, however, is not static. Individuals move in and out of categories of coverage and gain and lose coverage.

Sources of Coverage — All Ages. Of all Iowans, 59 percent are covered through employer-based coverage, 6 percent through individual coverage, 12 percent are covered through Medicare, 12 percent are covered through Medicaid, and 1 percent is covered through other public coverage.³



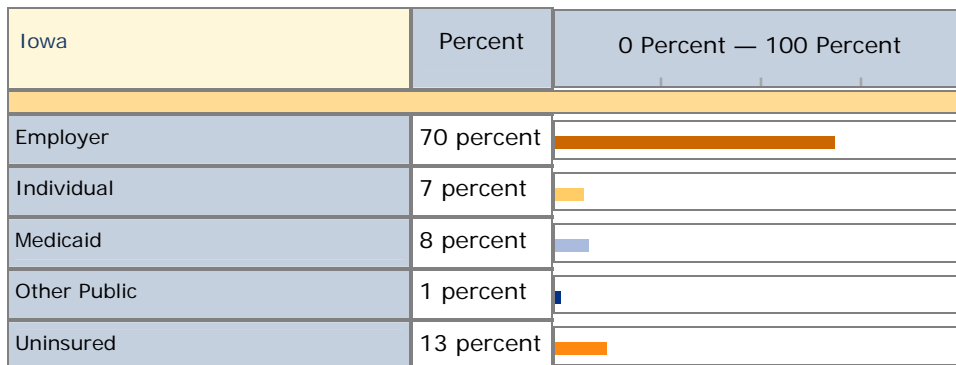
Health Insurance Coverage of Total Population, Iowa (2005-2006)

Sources of Coverage — Adults 19-64 Years of Age. For insured adults, the majority of health insurance provided is employer-based (70 percent), 7 percent are covered through individual



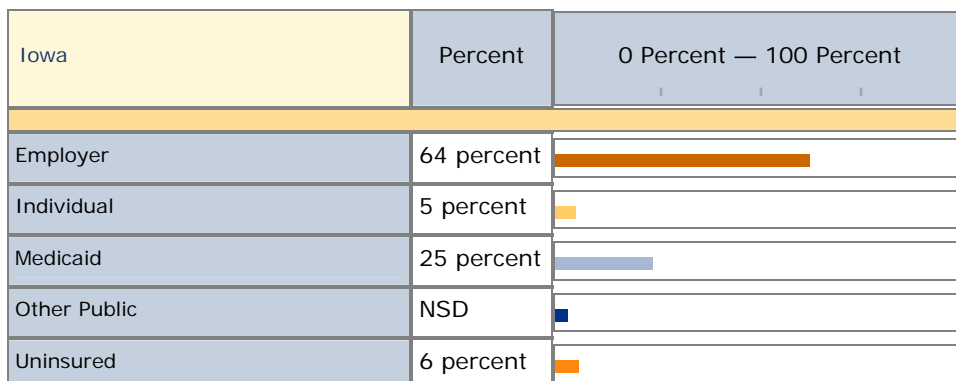
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coverage, 8 percent are covered through Medicaid, and 1 percent is covered through other public coverage.⁴



Health Insurance Coverage of Adults 19-64, Iowa (2005-2006)

Sources of Coverage — Children. The sources of health insurance for children 0 to 18 years of age include employer-based (64 percent), Medicaid/other public (25 percent); and individual (5 percent).⁵



Health Insurance Coverage of Children 0-18, Iowa (2005-2006)

B. Iowa's Uninsured

Even though Iowa, when compared with other states, has a low percentage of uninsured, a significant portion of the population remains uninsured. Additionally, for those who currently are insured, coverage is uncertain and increasingly unaffordable leaving many on the brink of joining the ranks of the uninsured. Sixty percent of adults responding to an Iowa-specific survey reported that they fear losing coverage, 60 percent were making sacrifices to maintain coverage, and others reported that they found it almost impossible to purchase their own coverage or delayed important needed care.⁶ The percentage of uninsured, while relatively stable from month to month, is not comprised of the same individuals from month to month and year to year. Many individuals lose



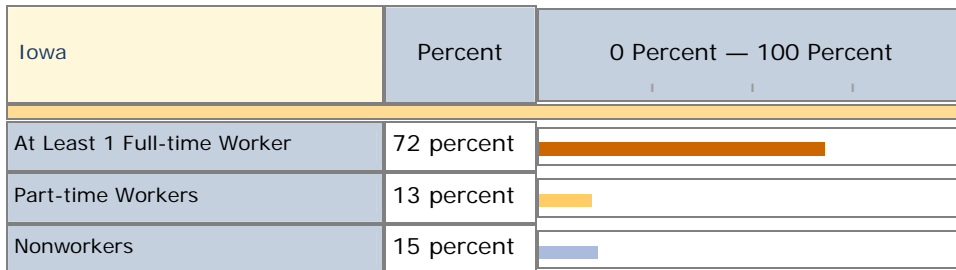
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coverage and regain it over the course of a year, and this dynamic nature of the uninsured complicates the development of strategies to be used in addressing the issue of the uninsured.⁷

- **Total Uninsured.** According to one national source, approximately 274,000 lowans are uninsured, based upon a total population estimate of 2.9 million.⁸ The Department of Human Services (DHS) estimates that for calendar year 2008 the total number of uninsured in Iowa will be 268,000 based upon a total population estimate of approximately 3 million.⁹
- **Uninsured Adults (19-64 years of age).** Of Iowa’s population of adults 19-64 years of age, one national source estimates that 13 percent, or approximately 229,000, are uninsured.¹⁰ The DHS estimates that for calendar year 2008 there will be approximately 1.8 million adults 19-64 years of age and approximately 12 percent of these adults, or 222,000, will be uninsured.¹¹

The majority of these uninsured are employed. Of the nonelderly uninsured (0-64 years of age), 85 percent have family work status described as having at least one full-time worker or part-time workers, and only 15 percent have a family status described as nonworkers.¹²



Distribution of Nonelderly Uninsured by Family Work Status, Iowa (2005-2006)

Working-age lowans who are uninsured in most cases are working for businesses that do not offer insurance and have wages that are too low to purchase coverage privately.¹³

- **Uninsured Children.** Of Iowa’s approximately 740,000 children 0-18 years of age, one national estimate of uninsured children in Iowa is 6 percent.¹⁴ The 2005 Iowa Child and Family Household Health Survey, which provided Iowa-specific data through a survey of over 3,600 families, found that the uninsured rate for children was 3 percent, down from 6 percent reported in a similar survey conducted in 2000.¹⁵ The DHS estimates that in calendar year 2008 there will be approximately 709,000 children in Iowa ages 0-18 with 6 percent, or 44,000, uninsured.¹⁶

The main reason for the lack of insurance coverage among children relates to high costs, job loss, or loss of benefits. The 2005 Iowa-specific survey also found that the majority of uninsured children are potentially eligible for either Medicaid or hawk-i.¹⁷

- **Uninsured by Income Level**



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- **Uninsured Children.** The DHS estimates that for calendar year 2008, of the total of approximately 44,000 children (ages 0-18) uninsured in Iowa, approximately 19,000 will have incomes below 200 percent of the FPL, approximately 16,000 will have incomes of between 200 percent to 400 percent of the FPL, and approximately 9,000 will have incomes of 400 percent of and above the FPL.¹⁸
- **Uninsured Young Adults.** The DHS estimates that for calendar year 2008, of the total of approximately 518,000 young adults (ages 19-30), approximately 106,000 will be uninsured. Of this number, approximately 73,000 will have incomes below 200 percent of the FPL, approximately 26,000 will have incomes from 200 percent to 400 percent of the FPL, and approximately 6,000 will have incomes of 400 percent of and above the FPL.¹⁹
- **Uninsured Older Adults.** The DHS estimates that for calendar year 2008, of the total of approximately 805,000 adults (ages 31-50), approximately 70,000 will be uninsured. Of this number, approximately 34,000 will have incomes below 200 percent of the FPL, approximately 19,000 will have incomes from 200 percent to 400 percent of the FPL, and approximately 17,000 will have incomes of 400 percent of and above the FPL.²⁰
- **Uninsured Pre-Medicare Adults.** The DHS estimates that for calendar year 2008, of the total of approximately 537,000 pre-Medicare adults (ages 51-64), approximately 45,000 will be uninsured. Of this number, approximately 21,000 will have incomes below 200 percent of the FPL, approximately 18,000 will have incomes from 200 percent to 400 percent of the FPL, and approximately 6,000 will have incomes of 400 percent of and above the FPL.²¹
- **Uninsured Adults Ages 65 and Older.** The DHS estimates that for calendar year 2008, of the total of approximately 443,000 adults ages 65 and over, approximately 2,000 will be uninsured. Of this number, approximately 1,000 will have incomes below 200 percent of the FPL, less than 1 percent will have incomes from 200 percent to 400 percent of the FPL, and approximately 1,000 will have incomes of 400 percent of and above the FPL.²²

(Appendix XII, Iowa Health Insurance Status Summary Charts)

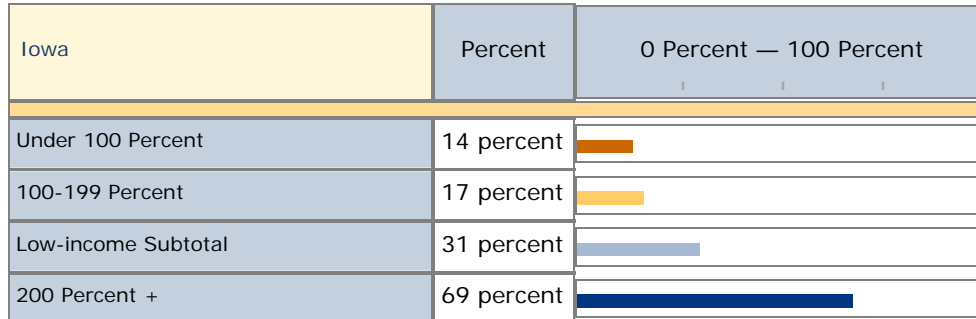
C. Other Significant Iowa Demographic Statistics

- **Racial, Ethnic, and Socioeconomic Disparities.** The population of minority residents in Iowa continues to grow. From 2000 to 2006, the Hispanic population in Iowa increased by 24 percent, the Asian population by 24 percent, and the African-American population by 15 percent.²³ The total minority population in Iowa in 2006 was 9 percent.²⁴ Additionally, the percentage of low-income individuals with incomes below 200 percent of the FPL was 31 percent in the period 2005-2006.²⁵



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Distribution of Total Population by Federal Poverty Level, State (2005-2006), U.S. (2006)

These demographic statistics are relevant to health care reform because disparities related to race, ethnicity, and socioeconomic status are still prevalent in the health care system. These disparities exist across all dimensions of quality, access, levels of health care including preventive care, treatment of acute conditions, and management of chronic disease, clinical conditions, and care settings. Additionally, disparities exist within subpopulations such as women, children, elderly, rural residents, and persons with disabilities or special needs.²⁶ Research has consistently documented that minorities have poorer health than do whites, due to a variety of factors including poverty, issues of access to and utilization of health care, issues of individual and institutional racism, lifestyle choices, and inadequate cultural competence by health providers and programs.²⁷

- Large Rural Population.** Roughly 41 percent of Iowa's population is rural.²⁸ Because of this demographic characteristic of Iowa, any health care reform must address issues specific to rural areas. On a national level, these issues include that, compared with urban residents, rural residents have higher poverty rates; a larger percentage of elderly; tend to have poorer health; have fewer doctors, hospitals, and other health resources; and have more difficulty getting to health services.²⁹ Additionally, rural primary care providers are more likely to be family physicians or generalists, almost 90 percent of the mental health profession's shortage areas are in rural counties, rural areas are marked by a lack of access to dental services due to a lack of supply of dentists (11 percent of rural residents have never seen a dentist), and first responder emergency services rates and transport times are greater.³⁰ One source reports that, "The rural population is consistently less well off than the urban population with respect to health." More rural residents have arthritis, asthma, heart disease, diabetes, hypertension, and mental disorders than their urban counterparts. The proportion of rural residents with chronic conditions is larger. Even though there are higher rates of elders and higher rates of disabilities in rural areas, rural residents receive comparable or less care suggesting that care may not be adequate. Rural residents receive fewer regular medical check-ups,



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blood pressure checks, cholesterol checks, pap tests, and mammograms than they should. This results in worsening health status and increases in chronic conditions. Rural residents are also more likely to engage in risky behaviors such as smoking and alcohol consumption, are more likely to be overweight and exercise less, and more are underinsured or uninsured for longer periods of time.³¹

- **Increasing Aging Population.** The median age of Iowa's population has increased from 36.6 years of age in April 2000 to 37.8 years in July 2006. Iowa ranks third in the nation in the number of residents over the age of 85 (2.5 percent) and fourth in the nation in the number of residents over the age of 65 (14.6 percent).³² While the percentage of the population of those under 18 and those between the ages of 18-64 is estimated to decline from 2010 to 2030 (from 23.6 percent to 22.4 percent and from 61.4 percent to 55.1 percent, respectively), the percentages of the population between the ages of 65-84 and those 85 years of age and older are projected to increase (from 12.1 percent to 18.9 percent, and from 2.8 percent to 3.6 percent, respectively).³³ In 2030 it is also projected that the number of counties with more residents age 65 and older than residents under the age of 18 will increase to 71.³⁴ The University of Iowa Center on Aging reports that most older persons have at least one chronic condition and many have multiple conditions including hypertension, arthritis, hearing impairments, coronary heart disease, cancer, diabetes, and stroke. Of those aged 80 and older, 71.5 percent report at least one disability. Those 80 and older have more difficulty with activities of daily living (27.5 percent or about double the percentage of those 65 years of age and older in total).³⁵ Adults age 65 and older have the highest health care spending, averaging \$8,647 per person in 2004.³⁶

D. The Private Insurance Market

Overview. Three primary markets for private major medical health insurance exist in this state: individual, small employer group (2-50 employees) and large employer group (over 50 employees).³⁷

Iowa currently has 28 insurance benefit mandates relating to coverage of certain providers, treatments, and illnesses. In comparison with other states, Hawaii and Utah have the lowest number of mandates with 22 each, and Maryland leads with 60 mandates.³⁸

Many large Iowa employers have self-funded health insurance plans, subject to the Employee Retirement Income Security Act (ERISA) but not subject to regulation by the state. It is estimated that 75 percent of health care insurance dollars spent in Iowa are not affected by the state's regulatory power.³⁹

A majority of businesses in Iowa are small businesses, with less than 50 employees and most have less than 10 employees. In the small group health insurance market 28 carriers sell such insurance, but six of those carriers sell over 90 percent of the insurance. This situation is comparable to that found in other states.⁴⁰



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Small Business Coverage. Small businesses face unique disadvantages in providing health insurance to their employees. Only 36 percent of Iowa businesses with fewer than 10 employees offer health insurance to any of their workers, compared with 94 percent of businesses with 50-249 employees and 100 percent of businesses with 1,000 or more employees.⁴¹

The smaller size of these groups results in higher administrative costs of insurance and limited ability to spread health care risk, which in turn increases premiums, adding to making health insurance unaffordable for both small businesses and their employees. In addition, state benefit mandates which are often not applicable to large employers do apply to most small businesses and are another cost driver for increased premiums. The cost of these mandates is estimated to be approximately 10-15 percent of premium rates.

Large Employer Coverage. Rapidly escalating health care costs are also creating difficulties for large employers and their employees. Employers are increasing deductibles and co-pays or otherwise reducing benefits in an effort to slow the increasing cost of providing coverage to their employees.⁴² While Iowa has not yet had a significant number of large employers terminating health insurance coverage, there is a fear that this may well result in the future if health coverage costs continue to spiral upward.

E. Major Factors and Trends That Challenge Health Care Reform

Even though Iowa has made progress in reducing the percentage of its citizens who are uninsured, a sizeable portion of Iowans remains uninsured, and these uninsured impact the entire system. Additionally, as is the case nationally, Iowa is plagued by a number of challenges that are endemic in the current health care system and threaten future progress.

Rising health care costs make the current system of health care coverage and health care delivery unsustainable.

Even if health care coverage is made available to all, a looming **health care provider shortage** threatens accessibility to necessary health care.

Even though Iowa's health care system performance is ranked high, the **poor health status of Iowans**, especially relative to the prevalence of chronic disease and poor health choices, will significantly affect the future of the health care system in the state.

Finally, **systemic flaws** of the health care system itself must be addressed to improve and sustain a viable health care system.

1. The Impact of Being Uninsured

Health Outcomes. Being uninsured results in serious health consequences and inferior outcomes for the uninsured:

- Lack of insurance compromises the health of the uninsured, who receive less preventive care, are diagnosed at more advanced stages of disease, and once



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diagnosed receive less therapeutic care and have higher mortality rates than the insured.

- Approximately 20 percent of the uninsured, compared with 3 percent of those who have coverage, use the emergency room as their usual source of care.
- Nationally, approximately 18,000 excess deaths occur among uninsured adults ages 25-64, annually.
- Uninsured children are much less likely to receive a well-child checkup. Nationally, in 2003, 50 percent of uninsured children did not receive these checkups compared with 26 percent of insured children.

Financial Consequences. The uninsured create financial consequences, including additional costs to and cost-shifting within the health care system. The costs of paying for care for the uninsured are passed down to all health care consumers and taxpayers. Prices for health care services, and as a result health care insurance premiums, increase to compensate for providing unreimbursed care to the uninsured:

- The United States spends approximately \$100 billion annually to provide uninsured residents with health services, often for preventable diseases that could have been treated more efficiently with earlier diagnosis.
- Nationally, hospitals provide about \$34 billion in uncompensated care annually.
- An additional \$37 billion is paid by private and public payers and \$26 billion is paid out-of-pocket by the uninsured.
- The uninsured are 30-50 percent more likely to be hospitalized for an avoidable condition, and the average avoidable hospital stay costs approximately \$3,300.⁴³
- It was estimated in 2000 that the annual economic value of foregone health among the then 40 million uninsured was between \$65 billion and \$130 billion. By inflating the midrange of this estimate forward to 2004 dollars, the estimated economic value in 2004 was \$103 billion.⁴⁴
- The Iowa Hospital Association estimates that in 2005 its 117 member hospitals provided uncompensated care valued at more than \$465 million based on charges, approximately \$228 million of which was charity care and \$237 million of which was bad-debt expenses. Based on costs, total uncompensated care in 2005 was approximately \$239 million, \$119 million of which was charity care and \$121 million of which was bad-debt expenses.⁴⁵
- One estimate is that the added cost to Iowa families' premiums caused by uncompensated care was \$500 in additional premium cost in 2005.⁴⁶

2. Rising Health Care Costs and Unaffordable Health Care Coverage

Health Care Spending and Rising Costs. In 2005 the United States spent \$2 trillion on health care, which is 16 percent of the gross domestic product and \$6,697 per person. Nationally, health care costs have grown an average of 2.5 percent faster than the United



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States' gross domestic product since 1970. Increases in health care costs impact households, businesses, and the government by placing increased pressure on businesses who offer coverage to employees, inhibiting individuals from purchasing their own coverage, placing increased financial burdens on families, and utilizing increasing portions of government budgets and taxpayer dollars.⁴⁷ Since the late 1970s the share of personal income going toward health care expenditures has tripled, while the rate of savings is negative. Today, health care is the number one cause of personal bankruptcy. In 2005 state and local governments, nationally, spent 21 percent of their budgets on health which was almost double the percentage spent in the 1970s. Payment for these increased costs came in the form of a reduction in spending for education from 39 percent to 32 percent, a reduction in spending on human services from 11 percent to 8 percent, and a reduction in spending on transportation from 8.7 percent to 5.5 percent.⁴⁸

Health care spending in Iowa totaled over \$15 billion in 2004, with the state ranking twenty-second in the nation in health care spending.⁴⁹ Between the years 1991 and 2004, the average annual percentage growth in health care expenditures in Iowa was 6.4 percent.⁵⁰ Iowa health care expenditures per capita in 2004 were \$5,380.⁵¹ Total health care expenditures as a percent of the gross state product in Iowa were approximately 14 percent in 2004.⁵²

Impact on Consumers

- Some Iowans are responding to increased health care costs by delaying care when sick, not following through on recommended treatments, and incurring more personal debt when medical care is unavoidable.
- Even though some Iowans, regardless of insurance status, act against medical advice in response to rising health costs, the uninsured or underinsured do so in greater percentages than those who are insured.
- The underinsured, those who rate their care as barely adequate, are increasingly making choices that increase their medical vulnerability.
- Issues relating to health care costs and coverage influence individual and family matters beyond health, including decisions about when and if to get married or start a family, job choice and mobility, investments, and workforce entry, entrepreneurship, and retirement. Iowans affected are making sacrifices in their household budgets by reducing the amount they save, reducing the amount spent on leisure activities, and reducing the amount spent on basic household expenditures such as food and utilities, taking on more debt, downgrading their scope of health insurance coverage to reduce costs, and reducing or eliminating other kinds of insurance coverage.⁵³

Impact on Employers. The costs of employer-sponsored health care plans continue to increase, resulting in challenges to employers' ability to provide comprehensive benefits.



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Even though employer-sponsored insurance in Iowa provided to individuals 0-64 years of age decreased by only 2.8 percent in the period between 2005 and 2006,⁵⁴ during the period 2000-2007 across all industries:

- Medical plan in-network deductibles increased for a single plan by 205 percent and for a family plan by 192 percent.
- Out-of-pocket maximums increased for a single plan by 99 percent and for a family plan by 103 percent.
- Office co-pays increased by 62 percent.
- Prescription drug co-pays increased by 63 percent for generics, 87 percent for preferred, brand-name; and 70 percent for nonpreferred, brand-name.
- Monthly premiums increased for a single plan by 84 percent and for a family plan by 87 percent.
- Employee contributions increased for a single plan by 41 percent and for a family plan by 67 percent.
- Annual single medical contributions increased by a total of 78 percent, with the employee contribution increasing by 40 percent and the employer contribution increasing by 88 percent.
- Annual family medical contributions increased by a total of 84 percent, with the employee contribution increasing by 84 percent and the employer contribution increasing by 97 percent.
- Even with ever-increasing costs, the percentage of the monthly premium borne by the employer (and the employee) has remained relatively consistent over this time period.⁵⁵

Employers in Iowa recognize the benefits of providing health insurance to attract or retain employees, keep employees healthy, and be good corporate citizens. Overall, 92.1 percent of employers in Iowa offer health insurance benefits, with a greater percentage of large employers offering health insurance benefits than do smaller employers. The majority of Iowa businesses have absorbed the increased costs and lived with lower profits rather than shift the increase to employees, but the majority of Iowa businesses also report that they will require employees to pay more of their premiums in the future if costs continue to rise. With 76.3 percent of employers reporting increases in insurance rates with an overall average increase of 8.2 percent, some employers have already responded by increasing employee contributions (48 percent of employers), raising deductibles (26 percent of employers), increasing office co-pays (19 percent of employers), and raising out-of-pocket maximums or increasing prescription drug co-pays (17 percent of employers).⁵⁶



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The increasing cost of health care coverage has also resulted in a business climate in which 92 percent of businesses agree that companies are being hurt by the cost of health insurance, 55 percent report that their companies are not as financially successful as they could be, and 79 percent report that health insurance is creating a state of crisis for business. Increased health insurance costs result in businesses leaving positions open, lost state income tax from less profitable businesses, and lost state sales tax revenue as businesses spend more on health insurance and less on taxable business equipment and other investments. This climate threatens future planning and expansion and even the viability of businesses.⁵⁷

Impact on State Government. Increases in health care costs also have repercussions for state government finances and limit the revenue available for other public necessities.

- **Medicaid.** Medicaid expenditures as a percent of total state expenditures were 18.3 percent in FY 2003, 17.8 percent in FY 2004, and 15.1 percent in FY 2005.⁵⁸ Total state and federal Medicaid spending in Iowa for FY 2006 was over \$2.6 billion.⁵⁹ Although the average annual growth in Medicaid spending in Iowa is slowing, average annual growth was 9.2 percent for the Fiscal Period 1990-2001, 10.4 percent for the Fiscal Period 2001-2004, and 7.1 percent for the Fiscal Period 2004-2006.⁶⁰
- The Medicaid program will have more than 466,000 unduplicated Iowans enrolled during FY 2009. This program provides health care coverage for almost 16 percent of Iowa's population at some point during the year. Medicaid will provide health care coverage for 230,670 (49 percent) children, 100,588 (22 percent) adults, 90,870 (20 percent) disabled, and 42,872 (9 percent) elderly. These enrollment figures include 17,287 adults in the IowaCare Program and 22,460 women in the family planning waiver. Enrollment in the regular, full-benefit Medicaid program at any given point in time is estimated to be 312,176 for FY 2009.⁶¹
- **IowaCare.** In 2005, Iowa implemented a program under a Medicaid waiver known as the IowaCare Program to cover low-income adults ages 19-64 who had an adjusted income of below 200 percent of the FPL, who are not eligible for Medicaid, do not have other health insurance, and meet other program criteria relating to cost-sharing, unless exempt. Eligible individuals include single people, childless couples, and parents of children under the hawk-i Program. IowaCare has a limited benefits package and the group of participating providers is limited to Broadlawns Medical Center in Des Moines, the University of Iowa Hospitals and Clinics in Iowa City, and the state's four mental health institutes.⁶² As of June 30, 2007, there were 18,327 members in the main demonstration population.⁶³ For FY 2006, total enrollment in IowaCare was 17,728, for FY 2007 total enrollment was 18,306, and total enrollment for FY 2008 is estimated to be 19,777.⁶⁴



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- **State Children's Health Insurance Program (SCHIP).** In Iowa, SCHIP is comprised of two portions: A Medicaid expansion portion and a separate program, hawk-i. The Medicaid expansion portion provides coverage to children who are ages 6-18 whose family income is between 100 and 133 percent of the FPL and infants whose family income is between 185 and 200 percent of the FPL. Children under the Medicaid expansion portion receive the same services as any other child eligible for Medicaid. The hawk-i portion provides health care coverage to children who are under age 19, are uninsured and do not qualify for Medicaid, and live in a family whose income is between 133 and 200 percent of the FPL. Children covered by the hawk-i portion receive a comprehensive package of health care benefits. In FY 2007, the Medicaid expansion portion of SCHIP provided coverage to 11,580 children and the hawk-i portion provided coverage to 21,924 children for a total of 33,504 children. The projected number of children that will be covered in FY 2008 is 39,004 (25,674 in hawk-i and 13,330 in the Medicaid expansion portion). For FY 2009, a total of 44,504 children are projected to be enrolled in the program with 29,424 enrolled in hawk-i and 15,080 children projected to be enrolled in the Medicaid expansion program. The total state budget required to meet this projected enrollment level is approximately \$28 million.⁶⁵

3. Poor Health Status, Unhealthy Behaviors, and Chronic Disease

Even though Iowa ranks second in health system performance, the state has fallen in health status among the states declining from sixth in 1990 to eleventh in 2007.⁶⁶

The United States Centers for Disease Control and Prevention report that the four factors influencing health are personal behavior, the environment (elements in the air, water, homes, communities, workplaces, and food that cause disease), access to health care, and genetic makeup. Of these, personal behavior is the most pertinent, while access to health care is the least. However, 88 percent of health resources is spent on treatment and only 4 percent on changing personal behavior.⁶⁷ Fifty to 70 percent of all health care costs and premature deaths, illnesses, and disabilities is related to behaviors. Two specific behaviors in point, tobacco use and obesity, add increased financial and social costs. An average of 10 percent of total claims costs is directly attributable to tobacco use. Annually, smokers cost \$1,623 in excess medical expenditures and \$1,760 in lost productivity compared to nonsmokers. Smoking is the leading risk factor for asthma, cancer, diabetes, heart disease, and chronic obstructive pulmonary disease. An average of 10 percent of total claims costs is directly attributable to obesity. Annual medical expenses for persons with a body mass index (BMI) of between 30 and 34 cost \$1,400 (or 25 percent) more than for persons with a BMI of less than 25; for those with a BMI greater than 35, the cost is \$2,267 (or 44 percent) more than persons with a BMI of less than 25; and sick days of those who are overweight are two to three times those of persons with normal weight, costing employers \$1,500-\$2,000 annually in excess sick pay. A person with a BMI of 25 or greater is subject to



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increased incidence of diabetes, heart disease, strokes, joint replacements, and back problems.⁶⁸

As noted above, unhealthy behaviors often lead to chronic disease, and the increased incidence of chronic disease among lowans has greatly contributed to the state's decline in health status. Chronic diseases are among the most prevalent, costly, and preventable of health problems. Chronic diseases are ongoing, generally incurable illnesses or conditions such as cardiovascular disease, asthma, cancer, and diabetes, but many are preventable through elimination of health-damaging behaviors and generally are manageable if diagnosed early and treated appropriately. More than 1 million lowans suffer from at least one chronic disease. Chronic diseases are the leading cause of death and disability in the state. Approximately 23 percent of lowans are affected by cardiovascular disease, 10 percent by asthma, 8 percent by depression, 5 percent by diabetes, and 5 percent by cancer. The percent of lowans considered obese (a BMI of 30 or more) increased from 13 percent in 1990 to 25 percent in 2005. The estimated cost of chronic diseases to Iowa including direct and indirect costs, such as lost productivity, is \$7.6 billion. Additionally, Iowa spends an estimated \$783 million in obesity-related medical expenditures each year.⁶⁹

4. Health Provider Shortages

Given Iowa's large rural and aging population, Iowa is facing significant challenges in recruiting and retaining an adequate supply of health care professionals. A 2005 report undertaken by the Department of Public Health through the Center for Health Workforce Planning reported the following findings related to the health care workforce:

- Of the 24 health professions studied, 15 health professions, or 63 percent, projected 20 percent or more of their licensees to be age 55 and older in 2005. In descending order of prevalence, the professions include psychologists (47 percent), health services providers (45 percent), marital and family therapists (38 percent), nursing home administrators (38 percent), mental health physicians (35 percent), mental health counselors (34 percent), dentists (34 percent), social workers (28 percent), advanced nurse practitioners (24 percent), physicians and registered nurses (23 percent), and chiropractors, licensed practical nurses, optometrists, and pharmacists (22 percent).
- The professions serving the mental health needs of lowans have the highest combined percentage of licensees age 55 and older and are at greatest risk of having a shortage of workers.
- Fewer individuals are entering at least 10 licensed professions. There are fewer 30-40-year-olds in the majority of the professions than there are 40-50-year-olds and often there are fewer 40-50-year-olds compared to 50-60-year-olds in a profession. These declines will impact the future ability of these professions to provide adequate services, especially to an aging population.



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- All but five of Iowa's health care occupations exceed the national average of workers who are age 55 and older, increasing the risk for shortages in all but the professions of respiratory care practitioner, emergency medical technician, physician assistant, physical therapist, and occupational therapist.⁷⁰

Key findings of the 2007 report of the Task Force on the Iowa Physician Workforce indicate:

- Iowa's overall supply of physicians has increased by 54 percent since 1980, but Iowa faces geographic and financial challenges in recruiting and retaining physicians. The main reason physicians leave is to move to another state and Iowa ranks eightieth among 89 Medicare payment localities in terms of payment schedule.
- Only 32 of Iowa's 99 counties have at least one psychiatrist, limiting accessibility to mental health treatment statewide.⁷¹

Iowa has a large number of health professional shortage areas (HPSAs). These are federally determined geographic (a county or service area), demographic (low-income population), or institutional (comprehensive health center, federally qualified health center, or other public facility) in nature. The areas are also designated by health care type: primary medical care, dental, or mental health providers. Iowa has 214 primary care HPSAs. Thirty-eight counties are full or partial primary care HPSAs because they are geographic HPSAs in which the population-to-physician ratio is greater than 3,500:1, or because they are demographic HPSAs in which the population-to-physician ratio is greater than 3,000:1 and at least 30 percent of the members of the population have incomes below 200 percent of the FPL. The remaining primary care HPSAs are facility designations (the facility has a shortage of providers to serve the population it exists to serve) that include rural health clinics, community health centers, correctional facilities, and state hospitals. Iowa also has 49 dental HPSAs. There are 10 geographic dental HPSAs (the population-to-dentist ratio exceeds 5,000:1). Thirty-nine counties are demographic (based on special populations of low income and Medicaid recipients) dental HPSAs (with a population-to-dentist ratio of at least 4,000:1 and at least 30 percent of the population having income at or below 200 percent of the FPL). If the qualifier of having 30 percent of the population at or below 200 percent of the FPL did not exist, 89 of Iowa's 99 counties would be dental HPSAs. Finally, 84 of Iowa's 99 counties are mental HPSAs (there is at least a 20,000:1 population-to-psychiatrist ratio within a designated catchment area). Iowa has 16 catchment areas, most including multiple counties.⁷²

Two of many examples of health care provider shortage areas include:

- **Direct care.** Direct care workers, individuals who provide services, care supervision, and emotional support to people with chronic illnesses and disabilities, are among the lowest paid of health care workers and receive the most limited benefits including health care coverage. These factors along with working conditions, educational requirements, and other factors impact the



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supply. Turnover rates are high, with some categories of direct care workers having turnover rates of between 40 and 100 percent, annually.⁷³

- **Nursing.** Nationally, it is predicted that there will be a shortage of as many as 1 million registered nurses by 2020. Fewer individuals are entering and remaining in nursing, but the demand for nurses increases as the population ages. Nationally, nursing programs turned away about 150,000 qualified applicants for all degree levels in 2006, due in large part to faculty shortages. Faculty shortages are exacerbated by the inability of schools of nursing to compete with the higher pay and benefits offered to experienced nurses in the clinical setting compared with the academic setting. In Iowa, the pay for registered nurses is the lowest in the nation. In Iowa, supply and demand are also impacted by the rural nature of the state, the declining population between the ages of 18 and 24, the high percentage of nurses approaching retirement, and the diminished supply of new nurses.⁷⁴

5. Systemic Flaws in the Health Care System

A 2006 Commonwealth Fund report on the future of the United States health care system found that 75 percent of all adults surveyed reported that the health care system either needs fundamental change or complete rebuilding.⁷⁵

Lack of Coordination and Integration. In the current health care system, health care is generally delivered and paid for based on a patchwork of office visits, lab tests, hospital stays, and other responses to illness, administered and directed by a multitude of practitioners. In the current health care system, no one provider coordinates an individual's care in a comprehensive manner and payment is made for office visits, lab tests, or hospital stays, not for a comprehensive treatment strategy or episode of care that, if successful, results in a favorable outcome. This results in mistakes, waste, fraud, and inefficiency with one in five lab tests being repeated because previous records are unavailable, one in seven hospital admissions occurring for the same reason, and complex administrative costs which account for 25-30 percent of health care dollars spent (up to 50 percent of which pays for sending out bills and other insurance-related documents whose sole purpose is moving money from payers to providers).⁷⁶

Over 90 percent of adults endorse the importance of well-coordinated care and having one place or doctor responsible for providing routine and acute medical care and coordinating all their care needs. Seventy-five percent viewed having a patient-centered medical home as very important. Ninety-six percent also said that it is important to have care from different doctors coordinated. Other recent studies found that adults generally have short-term relationships with their physicians and often lack a regular source of ongoing care. Only 37 percent have had the same physician for the past five years or longer.⁷⁷



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A "Sick Care" Not a "Health Care" System. In the current health care system, the focus is on "sick care" rather than wellness and prevention. The focus on sick care means that consumers often do not have access to services they view as essential, such as preventive care, prescription drugs, dental care, vision care, or mental health services. This forces consumers to postpone medical intervention until they are actually sick, resulting in a more acute level of care and treatment and increased costs to the system.

Lack of Transparency, Insufficient Information Sharing, and Ineffective Communication With Consumers. In the current health care system, a lack of transparency and availability of information results in a failure to engage all participants in a personally meaningful manner. Consumers are not able to actively participate in maintaining their health when they lack sufficient information to make informed decisions about healthy lifestyles, appropriate health care, quality, and price. Providers are not able to make effective treatment decisions if the most complete, real-time medical information about a patient is not available.

Ninety percent or more of adults realize the importance of having easy access to their medical records, for all of a person's doctors to have easy access to the person's medical records, and giving doctors access to their medical records across sites of care. The reality is that only about 51 percent of adults have access to their records. Additionally, 92 percent of adults believe computerized medical records would be effective in improving quality, but a 2003 survey of physicians found that only 27 percent of physicians used electronic medical records routinely or occasionally.

With regard to quality and cost information, over 90 percent of adults express the importance of having access to information about the quality of care by different doctors and hospitals, and the importance of having information about the cost of care before they received it. However, in a survey of individuals with health insurance, only 15 percent reported having access to this information.⁷⁸

There are also many missed opportunities by physicians to communicate effectively, involve patients in treatment decisions, and recognize patients' concerns or preferences. Fifty percent of individuals reported that their doctor did not spend adequate time with them, and 40 percent stated they did not think their doctor listened carefully or explained things clearly. Communication between providers and patients goes both ways; 39 percent of adults report nonadherence to their doctor's advice.⁷⁹

Payment For Services Not Aligned With Health Care Decisions That Improve Quality and Control Cost. In the current health care system, the provider reimbursement system rewards more but not necessarily better care, and creates disincentives to improve quality and make more cost-effective treatment decisions. The majority of adults endorse the use of cost and quality information to determine physician payment, and 87 percent realize the importance for insurance companies to identify and reward doctors and hospitals for high quality and efficiency of care.⁸⁰



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Cost-shifting. In the current health care system, the actual costs of health care services are difficult to quantify and the charges attributed to these services are only tangentially related to whatever the cost is. The uninsured and those payors who price health care services insufficiently cause providers to negotiate with insurers to recoup these costs by increasing what they charge insurers for their members. Higher charges to insurers translate into increased premiums to individuals and employers. To complicate matters, insurers negotiate the prices they will pay for health care services with health care systems or providers, and these negotiated prices for the same health care services vary both by insurer and health care system/provider. Insureds pay higher or lower prices for the same health care services based on whether their health system/provider negotiated with their insurer first or best. The price of the same health care services for the uninsured, who do not have a forum to negotiate, is substantially higher than the price for any insured.

According to the Iowa Hospital Association, in Iowa in 2006, as a percentage of published hospital charges, Medicare paid 40.2 percent, Medicaid 44.7 percent, one insurer 50.8 percent, another 59.9 percent, remaining insurers 67.1 percent, and the uninsured paying directly, 94.4 percent. In other words, for a \$100 medical service, Medicare might pay \$40.20 while an uninsured individual might have to pay \$94.40 for the exact same service at the same facility. This results in huge cost-shifting between different classes of payers, with the uninsured hurt the most. It also makes transparency of cost information very difficult, raises administrative costs, and creates an unlevel playing field where one or two insurers dominate a market.

Administrative Complexity. In the current health care system, administrative complexity confuses patients, providers, and payers and results in increased cost. Nearly \$300 billion is spent annually on administration of the health care system. One category of administrative expenses alone, administrative expenses incurred by private health insurers, increased by 52 percent between 1999 and 2002.⁸¹ Thirty-nine percent of adults report that spending time handling paperwork or on medical bill and health insurance disputes was a serious problem. Among low-income adults the percentage increases to 46 percent.⁸²

Interrelated Issues. The flaws in the health care system are many, varied, and interrelated. The 2004 report of the National Coalition on Health Care, "Building a Better Health Care System," suggested that because the health care sector is so interconnected and the issues so numerous and interrelated, health care reform must address all of these flaws together and reform must be systemic and systemwide. The report also recommended that reform apply to all payers, patients, and providers in order to avoid losses to one sector at the expense of another.⁸³

III. Guiding Principles — Framing the Vision

In order to address Iowa's current health care crisis and its challenges, the Commission spent an entire meeting developing the principles which would guide its deliberations. At the Mason City



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meeting in August 2007, the Commission unanimously approved the following principles which guided its discussions and were the foundation of its recommendations:

- Principle 1: Coverage and care should be universal or near universal.
- Principle 2: Coverage should be affordable and take into account all health care costs.
- Principle 3: Everyone should have a medical home.
- Principle 4: Health care should be accessible.
- Principle 5: Financing should be a shared responsibility.
- Principle 6: Reforms should drive quality improvements and contain costs.
- Principle 7: Reforms should do no harm.
- Principle 8: Reforms must be sustainable and doable.

IV. Universal Health Care in Iowa — A Vision Now Within Sight

The future of Iowa health care will either be a system that provides good health care for most, or it will be a system that improves the health of many and the care for all.

The Commission believes that in a state that values all Iowans equally, it is worthwhile to pursue the goal of providing health care for every Iowan — a universal system that provides access to the best health care without regard to a person's socioeconomic status.

The Commission believes that full access to affordable and quality health care will greatly reduce the economic insecurity many Iowans feel about the effect of their health care costs on their family's finances or their business enterprise. Full access will reduce the anxiety many Iowans feel about managing their chronic diseases and it will promote better personal care in preventing future maladies.

The Commission believes that shared responsibility between the worker or other individual, the employer, and government will provide the best financial mechanism to insure universal coverage.

The Commission believes the health care system can be improved and the Commission's recommendations are directed to help Iowans be better prepared to get healthy and to stay healthy.

A. Access to Affordable Health Care Coverage for All Iowans

The whole point of universal health care is that everyone pays a share of the costs and in return everyone has insurance coverage if and when they need it. For those Iowans that cannot afford health care insurance, their share of the costs of participation will be based on their ability to pay.

The Commission believes all Iowans should have health care coverage that is affordable to them. Reform should start with coverage that maximizes participation in federal and state programs for



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the lowest income lowans. For those that cannot afford the cost of private health care coverage, the state would subsidize the costs, using a tiered scale and broad-based sources of funding. Those who can afford health care coverage should purchase it themselves.

The Commission believes that the present health care insurance mechanism should be modified so that:

- Individuals are required to secure public or private health care insurance.
- Private insurance is easily accessible to all lowans. Issues of insurability, rescissions, preexisting condition exclusions, portability, and high-rate premiums are resolved.
- Healthy competition exists among health insurers. The disparity is reduced between the amounts that different individuals or payers are required to pay for identical services from the same health care provider.
- Insurance is designed to encourage and promote wellness. Prevention, early diagnosis, best practices, and coverage of catastrophic costs will be meaningful components of each policy.
- Employed individuals will have the ability to use pretax dollars to pay for insurance through expanding the availability of section 125 of the United States Internal Revenue Service Code.
- Employers are encouraged, but not required, to provide and help fund health care insurance for their employees. Those that do not provide coverage are required to contribute to a pool to subsidize health care coverage for low-income individuals.
- Ongoing broad-based efforts improve the health of lowans, help lowans to become better consumers of health care, and slow down escalating health care costs. These efforts will allow all lowans access to affordable health care while the cost of state subsidies for low-income individuals remains at a manageable level.

B. Medical Home

A medical home is an evidence-based concept which, by providing superior and more cost-effective, patient-centered care, allows universal health care to be affordable and sustainable. A medical home recognizes the importance of a dental home, a vision home, and a pharmacy home. (As an example, during state fiscal year 2004, North Carolina implemented a medical home program, Community Care of North Carolina, at a cost of \$10.2 million. That year, the state saved \$124 million compared with state FY 2003. In state FY 2005 and 2006, the state saved a total of \$231 million.) To achieve this vision, medical homes need to follow the recommended guidelines of the National Committee for Quality Assurance.

All providers should establish personal relationships with patients and provide comprehensive evaluations and continuity of care over time. Processes and a team approach must allow patients to be seen promptly, receive coordinated medical care, have their chronic diseases managed, and have their medical information collected electronically.



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Patients who participate in their own medical care will maximize their health and minimize their medical conditions by accessing their medical information electronically, learning to understand and monitor their illnesses, assisting in their own wellness and prevention efforts, and utilizing that personal relationship with a provider.

By following this approach, the Commission believes that an appropriate test of the medical home concept will reveal a cost-containment element that is necessary to sustain this health care reform effort.

C. Best Practices in Wellness, Prevention, Early Diagnosis, and Chronic Disease Management

Iowa is a leader in the quality of health care provided to its citizens. However, patient safety and the provision of high-quality care still can be improved. Ensuring that all Iowa health care providers understand and utilize evidence-based practice guidelines will improve patient outcomes and slow escalating health care costs. Special focus should center on effective interventions to treat chronic illnesses such as diabetes, pulmonary disease, and cardiovascular disease that affect many Iowans. Chronic disease management programs that provide easy access to health care providers, regular monitoring, and patient incentives to follow treatment plans can improve Iowans' quality of life and reduce health care costs.

Iowa should be a leader in wellness, prevention, early diagnosis, and management of chronic disease by ensuring all health care providers understand and utilize best practices and utilize established protocols for treating chronic diseases to provide best results and make the best use of different health care professionals.

As health care costs continue to escalate, incentives and education need to drive individual responsibility for use of health care services and lifestyle choices that improve health while containing costs. A health and wellness strategies consortium, a group of public and private purchasers, payers, and providers of health care working collaboratively, would serve as a catalyst to advance voluntarily adopted strategies to improve quality of care, increase the availability of services, and contain costs.

D. The Health Care Workforce

Although it is well documented that having health care coverage greatly increases an individual's ability and willingness to access health care services, having health care coverage alone does not ensure access to health care services. Access requires that a sufficient number of appropriate health care professionals is available.

Globally, nationally, and locally, the health care delivery system is facing a health workforce shortage. Iowa's situation is made even more acute by demographic factors such as an increasingly aging portion of the population (a population sector that also places more demand on the health and long-term care systems); a more rural population, an increasing portion of which is elderly compounded by a trend of workers leaving rural counties; and an increasing number of



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health care professionals reaching retirement age at a time when the population base of younger workers is decreasing. The supply of workers is also affected by pay, benefits, working conditions, competition between rural and urban employers, national and global competition, and the state educational system's capacity for producing health care professionals.

The vision for the health care workforce is to provide a structure to coordinate health workforce planning, recruitment and retention efforts, and data collection, tracking, and accessibility efforts in an effort to stabilize and increase workforce capacity and provide a basis for data-driven decision making. Recruitment, retention, and education efforts should be enhanced through expansion of loan repayment and loan forgiveness opportunities, availability of an increased number of residencies and internships, and provision of technical assistance and mentoring strategies.

Efforts should continue to reimburse health care professionals at a level competitive with the global and national markets. Nurses, physician assistants, direct care workers, and other medical providers should be recognized as full partners in the health care system. The Commission envisions a future in which all health care workers are provided health care coverage, especially the direct care workers who labor to provide essential health care services for others while 45 percent of the time they are not able to afford health care coverage for themselves.

Finally, the health care workforce of the future should focus more on wellness and prevention, i.e., a "health care" not a "sick care" system, and should maximize best practices and efficiencies in the delivery of services. To achieve this, our medical education institutions must adjust their curricula to be more proactive in teaching preventive medicine. Efforts should be made to increase public awareness regarding the health care workforce shortage and its impact.

E. Cost Containment and Transparency

Controlling the cost of health care services has been an extraordinarily difficult task. New technology, costly pharmaceuticals, patient expectations about care, unhealthy lifestyles, unmanaged chronic diseases, and costly life-extending medical treatments that produce more costs than life quality all play a role in the ever-increasing cost of health care services.

The current provider reimbursement model that pays providers for services performed, rather than for quality health outcomes for their patients, has also further increased overall health care costs as providers maximize their potential earnings.

In addition, the end purchasers of health care services are virtually in the dark about the actual costs and quality of services. This has resulted in a market failure where health care consumers lack basic cost and quality information and the ability to play any meaningful role in questioning and advocating for cost containment or in making different health care buying decisions based on the costs of services.

The current health care payment system is very complex and cumbersome with government payers, insurers, and providers all negotiating different levels of discounts off of published prices. This results in significant cost shifting between different payers. The uninsured individual has little



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or no leverage and ends up the big loser. Moreover, it appears at this time that providers are hard pressed if not unable to provide interested consumers with basic, reliable information about the cost of their care.

The Commission believes the state needs to develop a transparency system that includes price, cost, and quality to provide health care consumers with useful information about provider costs, charges, and quality as well as insurance company payments. Having more informed health care consumers will not solve all cost concerns, but will provide a basis for consumers to make better health care choices. Promoting the development and public use of a price, cost, and quality transparency system in Iowa should be a high priority.

A need also exists to address cost containment from a longer term perspective as we change the provider reimbursement system to focus on prevention and better management of chronic diseases. Chronic diseases such as heart disease, stroke, diabetes, and cancer are among the leading causes of disability and death in the United States. Chronic diseases account for 70 percent of deaths and about 78 percent of health spending.

The Commission also believes that a public health, population-based approach will greatly improve the health status of Iowans by investing in tobacco use cessation and prevention initiatives and health promotion efforts that focus on eating smarter and exercising more. This approach is essential to controlling the exploding cost of unhealthy lifestyles.

Finally, the Commission believes the health care system in Iowa needs to aggressively eliminate duplication and unnecessary expenditures caused in part by constructing competing medical facilities.

F. Health Information Technology

Health information technology (health IT) is rapidly evolving and advancing toward its goal of increasing access to health care, improving the quality of health care, enhancing efficiency, and reducing costs.

Critical to the success of the health IT system is its widespread adoption. To be effective Iowa's health IT system must:

- Be patient-centered and market-driven. The market must provide users with a variety of certified products from which to select what best fits their specific needs.
- Be based on approved standards arising out of the work of the committees sanctioned by the Office of the National Coordinator for Health Information Technology of the United States Department of Health and Human Services, and sound principles developed with input from stakeholders.
- Protect the privacy and security of all health information and ensure the accuracy, completeness, and uniformity of data by establishing protocols and other measures that



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address critical problems such as unauthorized disclosure of protected health information and inaccurate or incomplete data.

- Provide incentives for health care providers to adopt the use of health IT and provide rewards for those providers who improve quality and efficiency through their use of health IT.
- Ensure that the system is paid for by all who benefit from the increased quality, safety, efficiency, savings, and any other benefits that result from health IT.

The Commission believes that these conditions can be met here in Iowa, and that steps should be taken to begin the implementation of an effective health IT system in this state.

The vision for health IT in Iowa should be implemented in two stages. Initially, Iowa should work to expand the access of telehealth/telemedicine throughout the state. This state is uniquely qualified to encourage development of such a system to connect the various facets of the Iowa's health care system. Long-term, the development of health IT will provide every Iowan the opportunity to have an electronic health record allowing each person to receive quality, appropriate care anywhere in Iowa.

To the end of expanding access to telehealth/telemedicine, the Commission supports the effective use of a statewide telehealth/telemedicine system that increases access to specialty care for underserved populations including rural Iowans, allows for increased opportunities to provide health education and training to address health care workforce shortages, and offers the capacity to effectively transfer large data files.

To the end of increasing the availability of electronic health records, the Commission supports immediate efforts to achieve the ultimate goal of an interoperable electronic health records system, with the understanding that this goal will take time to complete, will require answers to questions as yet unasked, and may change fundamentally over the course of its development.

The Commission also supports the creation of a state body to provide guidance and coordination in the expanded use of health IT and to serve as a resource for policymakers by formulating recommendations on health IT issues.

Utilizing this strategy will allow Iowa to move forward in the health IT arena so that the state is well-positioned to act as a model for the nation.

G. Health Care Insurance Consumer Advocate

The Commission believes the goal of providing consumer protection should be paramount. Going the "extra mile" in providing consumers with easy-to-understand, timely information about their questions, issues and complaints, and requiring insurers to stand behind their promises should be the norm.



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The Commission believes that an Office of Health Care Insurance Consumer Advocate should be created to act as an “ombudsman” that citizens can contact with complaints about rates, charges, rules, regulations, and insurance practices.

The Commission further believes that the office should represent the interests of the public relating to insurance reform, coverage, and rates where action is necessary for the protection of public rights and should provide education and information so consumers better understand their insurance policies.

H. Shared Responsibility — Patients, Payers, and Providers

The Commission believes that Iowa can achieve accessible, affordable, and high-quality health care coverage for all Iowans if there is meaningful “shared responsibility” among the “payers, patients, and providers.”

Unless reform is systemwide, gains in some sectors or for some groups are likely to be offset by losses elsewhere. There is, in addition to this practical consideration, another compelling argument for making certain that reform is systemwide.

America is already a nation of health care haves and have-nots. Reform should aim to assure that all Americans receive excellent health care and are able to enjoy the quality of life and peace of mind for which such care is essential. Piecemeal reform that helps some categories of people to the detriment of others would not take us closer to an optimal health care system and could actually make it harder to attain.⁸⁴

Patients — individuals and families are responsible for living healthier lifestyles – eating properly, refraining from smoking and excessive alcohol consumption, exercising, wearing seat belts, and obtaining appropriate, preventive care. In addition, patients must be better informed and more active participants in their own care.

Payers — employers remain the predominant source of health care coverage but small businesses, especially, are having greater difficulty in offering coverage to their employees. Insurers need to make sure that they do not discriminate in the provision of health care coverage. For insurance companies, shared responsibility includes working with the state to resolve issues of insurability, rescissions, preexisting condition exclusions, and portability.

Providers — health care providers need to be consistent in utilizing the best science, cooperating in the development of information technology, taking the time to explain treatment options to their patients, avoiding conflicts of interest in health care referrals, and charging reasonable amounts for their services.

State Government — as a provider and payer, state government must participate in a meaningful way. State government has a direct responsibility to fully fund Medicaid, IowaCare, and SCHIP (both the Medicaid expansion portion and hawk-i).



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This shared responsibility not only makes sense, it will also foster cooperation among Iowa's health care stakeholders in remedying the growing health care cost and coverage crisis. The Commission believes that health care reform deserves everyone's support.

I. Financing

The Commission believes that appropriate and significant contributions from individuals, businesses, and government are necessary to reach the goal of universal coverage. The Commission further understands that the burden must be shared and costs to achieve the goal are unavoidable. The choice boils down to making a commitment to lead the effort and find broad-based sources of funding to promote and provide for the health of **all** Iowans, versus giving up and accepting that too many Iowans will continue to have no access to quality, affordable health care. The Commission knows this is a tough choice, but not investing in a universal health care system now will inevitably result in an economic cost to the state, businesses, and individuals in the form of increasingly escalating health care costs and, eventually, higher taxes, and a human cost to society in the form of an increasingly inferior health status for its citizens and a less productive populace. For the Commission, the choice is clear, invest now.

J. Conclusion

The ideas the Commission is advancing are familiar to many in the health care profession: the importance of practicing preventive medicine, the benefits of health IT, the value of a greater role for the consumer, requiring health insurance coverage, and the need for better coordination between providers and insurers.

Health care spending in Iowa and the United States is projected to increase from 16 percent of the gross domestic product (GDP) in 2006 to 20 percent in 2016. At the same time the number of people who are uninsured is rising sharply, including a growing proportion of middle-income families. While rising costs are putting all sectors of the economy at risk, the nation lacks a concrete, realistic plan for adopting a different approach that could achieve savings and improve value.

Iowa alone cannot reduce costs, increase quality, and guarantee access; but states can no longer linger in the political "twilight zone" waiting for the federal government to act. Ten states are now initiating health care reform and Iowa is joining them. States, including Iowa, can significantly reduce the number of the uninsured, increase the quality of services, and make insurance more affordable to individuals, families, and small businesses.

The Commission has created a vision of what our health care system could be and has made specific recommendations. These recommendations represent a range of approaches that have been proposed to address the various factors that contribute to high and rising health care costs and the inefficiency in the current health care delivery and financing systems. Indeed, collaborative efforts across public and private sectors will be essential for achieving higher performance and greater value.



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Health care reform is upon us and the Commission believes that Iowa is well situated to take advantage of this moment and provide the leadership necessary to help its citizens find the health care security they need.

V. Commission Goals — Bringing the Vision Into Focus

The Commission divided into six work groups to develop recommendations on improving Iowa's health care system. The guiding principles were the standard the Commission used to direct its activities. The goals that emerged were the result of the deliberations and came directly from the work groups' final reports. Each Commissioner chose one of the six work groups to participate in. The work groups met from July through December. The Commission approved a series of detailed recommendations at its December 2007 meeting. These work group reports are contained in Appendix IX.

The goals listed below were extracted from the work group reports:

- All Iowans will have affordable health care coverage that meets certain minimum requirements. Iowans with high-cost health conditions will be protected from excessive out-of-pocket costs.
- Sufficient funding will be identified and used to make health care coverage more affordable for all Iowans.
- Iowans will have a guaranteed source for purchasing health care coverage using a mechanism that makes required participation as easy as possible and keeps administrative costs as low as possible.
- Health care providers' quality and price information will be broadly available and easily accessible.
- Every Iowan will have a patient-centered medical home, which emphasizes preventive care, wellness programs, and chronic disease management to reduce costs and increase quality of care.
- A wellness coalition will be formed to endorse common principles and direct strategies to contain costs, provide quality health care services, and reduce disparities.
- Iowa will be the national leader in development and use of health IT and telemedicine systems allowing providers to use aggregated patient data to improve the health care of Iowans, particularly in areas underserved by medical providers.
- The state will establish a statewide network to transfer health care information in a secure and reliable environment by using one or more dedicated fiber optic systems.
- Ongoing health workforce assessment and planning will be conducted to ensure improvement of wages for direct care workers and an increase in the number of practicing physicians, psychiatric residents, and other health care professionals in Iowa.



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- Whistleblower protections will be provided for health and long-term care workers in the private, nonprofit sector.

VI. Legislative Recommendations — Action Steps in 2008 — Processing the Vision

The six work groups made a total of 79 individual and detailed recommendations (Appendix IX). However, the Commission believes that the Legislature should commence its actions with essential but financially reachable goals during the 2008 Legislative Session. The Legislature should resist the temptation to delay the indispensable elements of a new health care system that will provide all Iowans with the best opportunity to have universal health care coverage. The legislative actions described below are achievable and will allow the Legislature to begin to deliver on its promise of providing affordable and accessible health care coverage as soon as the resources are available. To succeed, the Commission recommends the following action steps in 2008:

1. Develop and implement a plan for covering all children and fully funding Medicaid and hawk-i.
2. Establish the structure necessary to implement health care coverage for all Iowans through creation of the Health Care Exchange, a quasi-public, private agency that will develop, oversee, and implement universal coverage for all Iowans; lead health care quality, safety, and cost reduction initiatives; and create a transition plan until universal coverage is fully executed, to ensure that all Iowans have access to private insurance at a predetermined rate ceiling and without preexisting conditions exclusions.
3. Define what constitutes health care coverage:
 - Define minimum specifications for health care coverage plans that balance flexibility, affordability, and comprehensiveness by covering wellness, prevention, and diagnosis; covering catastrophic expenses; providing a reasonable level of basic care; and including prescription drugs and dental care.
 - Define parameters for affordability and levels of subsidization of private insurance premiums by utilizing a progressive scale of subsidization based on income. In defining what constitutes "affordable," the following recommendations should be considered:
 - Any affordability schedule should be a conservative measure, and should utilize a progressive scale as incomes increase. Using a conservative schedule will prevent harming people who are struggling financially.
 - People with very low incomes can pay only small amounts toward health care and no financial penalties should be imposed upon them. Research shows that many low-income people struggle to pay for basic necessities



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and are likely to have negative cash flow. In Massachusetts, studies indicate that families below 300 percent of the FPL may not have enough earnings to cover even basic needs.

- The upper-bound of affordability should be set at about 8.5 percent of income. Data shows that people with higher incomes can reasonably afford health insurance at 8.5 percent of income. People with unsubsidized, nongroup premiums currently pay an average of 8.5 percent of their income on health insurance.
 - Determine costs and funding sources for universal coverage.
4. Continue defining and planning how medical homes can be established for all Iowans, but in 2008 commit to a program of securing medical homes for a defined population.
 5. Create a statewide telehealth system using the Iowa Communications Network and private dedicated health care systems to deliver a mechanism for transmitting digital data on patient care and to develop the standards necessary for use of that mechanism by all health care professionals.
 6. Implement consumer-driven, medical provider quality improvement, and cost-containment strategies that will have more of an immediate impact on health care costs.
 - Continue overall planning around wellness, prevention, and diagnosis, but in 2008 commit to a focused, concentrated effort on a defined population.
 - Begin to create a system for all medical providers to disclose prices and performance quality.
 - Undertake a project in 2008 to develop and implement consensus guidelines to address one or two of the most significant chronic diseases.
 - Strengthen the certificate of need process.
 - Create an Office of Health Care Insurance Consumer Advocate.
 - Direct and support efforts that help consumers take more responsibility in the prevention or management of health problems. This includes improving health literacy to increase the communication and interaction between health care providers and patients and programs that encourage consumers to be responsible for their own wellness.
 - Begin an effort in 2008 to catalogue, communicate, and insure statewide compliance with key medical best practices.
 - Move forward with implementing educational workforce incentive programs.



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7. Contract with The Lewin Group to create an economic model of the Commission's health care proposal. This will provide the Legislature and the Governor with the closest estimate of the costs necessary to implement the Commission's action steps. After the estimates have been determined and the scope of the reform is decided by legislative action, it is the Commission's belief that the state should initially fund the legislative reforms by the best mix of recommendations determined in the report of The Lewin Group.
8. The Commission knows that sustainability is absolutely essential for an improved health care system to last. The Commission wants to move slowly but deliberately toward permanent and sustainable sources of revenue. The Commission believes that this has to be a shared responsibility between the patient, payer, provider, and federal and state government.

Note to reader: **Endnotes** All of the citations to Internet sources were last accessed on 1/8/2008.

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- ¹ Aiming Higher: Results From a State Scorecard on Health System Performance, The Commonwealth Fund Commission On A High Performance Health System, June 2007 http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=494551 and http://www.commonwealthfund.org/usr_doc/StateScorecard.pdf?section=4039.
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ATTACHMENT I

2007 Iowa Acts, Chapter 218, section 127

124 29 Sec. 127. LEGISLATIVE COMMISSION ON AFFORDABLE HEALTH CARE
124 30 PLANS FOR SMALL BUSINESSES AND FAMILIES.

124 31 1. A legislative commission on affordable health care
124 32 plans for small businesses and families is created for the
124 33 2007 legislative interim. The legislative services agency
124 34 shall provide staffing assistance to the commission.

124 35 a. The commission shall include 10 members of the general
125 1 assembly, three appointed by the majority leader of the
125 2 senate, two appointed by the minority leader of the senate,
125 3 three appointed by the speaker of the house of
125 4 representatives, and two appointed by the minority leader of
125 5 the house of representatives.

125 6 b. The commission shall include members of the public
125 7 appointed by the legislative council from designees of the
125 8 following:

125 9 (1) Two members who are small business owners, one
125 10 designated by the Iowa association of business and industry,
125 11 and one designated by the national federation of independent
125 12 business.

125 13 (2) One hospital administrator designated by the Iowa
125 14 hospital association.

125 15 (3) Two health care providers, one a physician designated
125 16 by the Iowa medical society, and one a nurse designated by the
125 17 Iowa nurses association.

125 18 (4) One individual insurance agent designated by the
125 19 independent insurance agents of Iowa.

125 20 (5) One representative of an insurance carrier designated
125 21 by the federation of Iowa insurers.

125 22 (6) One individual health insurance agent designated by
125 23 the Iowa association of health underwriters.

125 24 c. The commission shall include five consumers appointed
125 25 by the governor.

125 26 d. The commission shall include the following members, or
125 27 their designees, as ex officio members:

125 28 (1) The commissioner of insurance.

125 29 (2) The director of human services.

125 30 (3) The director of public health.

125 31 e. At least one of the members appointed or designated
125 32 pursuant to paragraph "a", "b", or "c" shall be a member of a
125 33 racial minority group.

125 34 2. The chairpersons of the commission shall be those
125 35 members of the general assembly so appointed by the majority
126 1 leader of the senate and the speaker of the house of
126 2 representatives. Legislative members of the commission are
126 3 eligible for per diem and reimbursement of actual expenses as
126 4 provided in section 2.10. Consumers appointed to the
126 5 commission by the governor pursuant to subsection 1, paragraph
126 6 "c", are entitled to receive a per diem as specified in
126 7 section 7E.6 for each day spent in performance of duties as
126 8 members, and shall be reimbursed for all actual and necessary

126 9 expenses incurred in the performance of duties as members of
126 10 the commission.

126 11 3. The commission shall review, analyze, and make
126 12 recommendations on issues relating to the affordability of
126 13 health care for Iowans including but not limited to:

126 14 a. The benefits and costs of requiring all residents of
126 15 Iowa to have health insurance coverage, including but not
126 16 limited to individual mandates and proposals from other
126 17 states.

126 18 b. The benefits and costs of providing health insurance
126 19 coverage to all children in the state, with a particular
126 20 emphasis on children's health issues.

126 21 c. Uninsured and underinsured Iowans with a special focus
126 22 on determining the characteristics of the uninsured and
126 23 underinsured populations, why such persons are uninsured or
126 24 underinsured, and the most effective and efficient means to
126 25 provide insurance coverage to such persons, including through
126 26 government programs.

126 27 d. Major factors and trends that are likely to impact the
126 28 cost of premiums and affordability of health care during the
126 29 next ten years, including but not limited to effects of
126 30 mandates, levels of coverage, costs and pricing of treatments,
126 31 cost-sharing and cost-cutting measures, cost-shifting
126 32 measures, collaborative opportunities, subsidies, reinsurance
126 33 plans, risk pooling, and wellness and disease prevention
126 34 initiatives.

126 35 4. The commission shall utilize the expertise of the
127 1 health care data research advisory council in carrying out the
127 2 commission's duties.

127 3 5. The commission may hold public hearings to allow
127 4 persons and organizations to be heard and to gather
127 5 information.

127 6 6. The commission may request from any state agency or
127 7 official information and assistance as needed to perform the
127 8 review and analysis required in subsection 3. A state agency
127 9 or official shall furnish the information or assistance
127 10 requested within the authority and resources of the state
127 11 agency or official. This subsection does not allow the
127 12 examination or copying of any public record required by law to
127 13 be kept confidential.

127 14 7. The commission may employ staff and consultants as
127 15 necessary to assist the commission in carrying out its duties
127 16 as set forth in this section.

127 17 8. The commission shall complete its deliberations in
127 18 December 2007 and submit a final report to the general
127 19 assembly for consideration during the 2008 Legislative
127 20 Session, summarizing the commission's activities, analyzing
127 21 issues studied, making recommendations for legislative reforms
127 22 that will make health insurance coverage more affordable for
127 23 small businesses and families in this state, and including any
127 24 other information that the commission deems relevant and
127 25 necessary.

Attachment II

Membership Specified

The legislation establishing the Legislative Commission on Affordable Health Care Plans for Small Businesses and Families directed that the membership of the Commission include:

- Ten members of the General Assembly, three appointed by the Majority Leader of the Senate, two appointed by the Minority Leader of the Senate, three appointed by the Speaker of the House of Representatives, and two appointed by the Minority Leader of the House of Representatives.
- Members of the public appointed by the Legislative Council from the designees of small business owners, one designated by the Iowa Association of Business and Industry and one designated by the National Federation of Independent Business; one hospital administrator designated by the Iowa Hospital Association; two health care providers, one a physician designated by the Iowa Medical Society; and one a nurse designated by the Iowa Nurses Association; one individual insurance agent designated by the Independent Insurance Agents of Iowa; one representative of an insurance carrier designated by the Federation of Iowa Insurers; and one individual health insurance agent designated by the Iowa Association of Health Underwriters.
- Five consumers appointed by the Governor.
- The Commissioner of Insurance, the Director of Human Services, and the Director of Public Health as ex officio members.

A representative of the Iowa Pharmacy Association and a representative of the Iowa Dental Association were also appointed to the Commission, as well as the Director of the Department of Elder Affairs as an ex officio member.

Membership List

Legislative Members (10):

1. Senator Jack Hatch (D) — Des Moines — Co-chairperson
2. Representative Ro Foege (D) — Mount Vernon — Co-chairperson
3. Senator Jerry Behn (R) — Boone
4. Senator Joe Bolkcom (D) — Iowa City
5. Senator Larry McKibben (R) — Marshalltown
6. Senator Amanda Ragan (D) — Mason City
7. Representative Clarence Hoffman (R) — Denison
8. Representative Dave Jacoby (D) — Coralville
9. Representative Mark Smith (D) — Marshalltown
10. Representative Linda Upmeyer (R) — Garner

Public Members Appointed by Legislative Council (10):

1. Mr. John Aschenbrenner — Des Moines — Designee of Federation of Iowa Insurers
2. Mr. Jay Christensen — Oskaloosa — Designee of Iowa Hospital Association
3. Ms. Amy DeBruin — Oskaloosa — Designee of Iowa Association of Business and Industry
4. Dr. Steven Fuller — Bondurant — Designee of Iowa Dental Association
5. Ms. Barb Kniff — Pella — Designee of National Federation of Independent Business
6. Dr. Timothy Kresowik — Iowa City — Designee of Iowa Medical Society
7. Ms. Julie Kuhle — Indianola — Designee of Iowa Pharmacy Association
8. Ms. Patsy Shors — Des Moines — Designee of Iowa Nurses Association
9. Mr. Russ Sporer — Ottumwa — Designee of Iowa Independent Insurance Agents
10. Mr. Joe Teeling — West Des Moines — Designee of Iowa Association of Health Underwriters

Consumers Appointed by Governor (5):

1. Dr. David Carlyle — Ames
2. Ms. Janice Laue — Des Moines
3. Mr. Eric Parrish — Des Moines
4. Ms. Sarah Swisher — Coralville
5. Ms. Sharon Treinen — Ackley

Ex Officio Members (4):

1. Mr. Kevin Concannon, Director of Human Services
2. Mr. John McCalley, Director of Elder Affairs
3. Mr. Tom Newton, Director of Public Health
4. Ms. Susan Voss, Commissioner of Insurance

Alternates:

1. Mr. Greg Anliker — Department of Elder Affairs
2. Ms. Angela Burke Boston — Insurance Division
3. Mr. Larry Carl — Iowa Dental Association
4. Mr. Gene Gessow — Department of Human Services
5. Ms. Karen Hanson — Federation of Iowa Insurers
6. Mr. Dan McGuire — Iowa Association of Business and Industry
7. Ms. Julie McMahon — Department of Public Health
8. Mr. Charlie Wishman — Alternate for Ms. Laue

ATTACHMENT III

2007 Iowa Acts, chapter 218, section 128

127 26 Sec. 128. HEALTH CARE DATA RESEARCH ADVISORY COUNCIL.
127 27 1. A health care data research advisory council is created
127 28 for the purpose of assisting the legislative commission on
127 29 affordable health care plans for small businesses and families
127 30 in carrying out the commission's duties by conducting
127 31 research, providing research data and analysis, and performing
127 32 other functions within the expertise of the members of the
127 33 council at the direction of the commission.
127 34 2. The council membership shall be appointed by the
127 35 legislative council and shall include but is not limited to
128 1 the following:
128 2 a. A representative of the university of Iowa college of
128 3 medicine.
128 4 b. A representative of the university of Iowa college of
128 5 dentistry.
128 6 c. A representative of the university of Iowa college of
128 7 pharmacy.
128 8 d. A representative of the university of Iowa college of
128 9 nursing.
128 10 e. A representative of the university of Iowa college of
128 11 public health.
128 12 f. A representative of Des Moines university ==
128 13 osteopathic medical center.
128 14 g. A representative of the Drake university college of
128 15 pharmacy.
128 16 h. A representative of an Iowa college of health sciences.
128 17 i. A representative of the Iowa public health association.

ATTACHMENT IV MEMBERS

HEALTH CARE DATA RESEARCH ADVISORY COUNCIL 2007

William Appelgate, Ph.D.
Des Moines University
Des Moines, IA 50312

James Merchant, M.D., DrPH
College of Public Health
University of Iowa
Iowa City, IA 52242

Christopher Atchison, MPA
College of Public Health
University of Iowa
Iowa City, IA 52242

JoAnn Muldoon
Iowa Public Health Association
Des Moines, IA 50319

Pete Damiano, D.D.S.
Public Policy Center
University of Iowa
Iowa City, IA 52242

Gary Rosenthal, M.D.
Carver College of Medicine
University of Iowa
Iowa City, IA 52242

Barbara Decker, J.D.
Mercy College of Health Sciences
Des Moines, IA 50309

Bernard Sorofman, Pharm. D.
College of Pharmacy
University of Iowa
Iowa City, IA 52242

Jane DeWitt, Ph.D.
Drake College of Pharmacy and
Health Sciences
Des Moines, IA 50311

Brenda Hoskins
Clinical Assistant Professor
College of Nursing
Iowa City, IA 52242

ATTACHMENT V

SUMMARY OF ADVISORY COUNCIL ACTIVITIES

Data Research Advisory Council Presentations

June 20, 2007

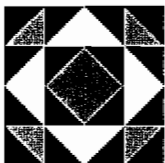
- Dr. James Merchant summarized the presentations by the keynote speakers and the discussions of the Iowa Panel of the Rebalancing Health Care in the Heartland Forum 2: A Focus on State-Based Health Care Reform held on June 19, 2007.

July 18, 2007

- Mr. Christopher Atchison reviewed the Data Research Advisory Council proposals and budgets with the Commissioners.

August 15, 2007

- Dr. Pete Damiano summarized for the Commissioners six recent healthcare surveys conducted in Iowa dealing with Iowa health insurance coverage of children, adults, and businesses, trends in coverage, the impact of coverage-related issues, and future possibilities for change.
- Dr. Pete Damiano also provided the Commissioners with the Prevention Priorities Policymakers Guide.



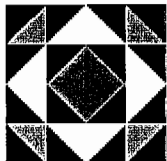
Data Research Advisory Council Presentations

September 19, 2007

- Dr. James Merchant presented the Commissioners with the pre-publication summary of the Rebalancing Health Care in the Heartland Forum 2: A Focus on State-Based Health Care Reform.
- Dr. Pete Damiano answered questions from the Commissioners on health care system frustrations, costs of care in Iowa, cost of state-supported insurance expansion, and dental insurance.

October 17, 2007

- Dr. William Appelgate presented to the Commissioners findings of the Iowa Rural Health Association Outlook on Health Survey.
- Dr. Jane DeWitt presented a report to the Commissioners which summarized policy tools that might improve access to medications and medication-associated services and enhance health outcomes and reduce program costs.
- Dr. Stacey Cyphert discussed with the Commissioners employer-based insurance and the future of employer-sponsored insurance and provided the Iowa Physicians Workforce Report.
- Dr. Pete Damiano further discussed the six reports on Iowa health insurance coverage with the Commissioners.



UI College of Public Health
Healthier Workforce Center for Excellence

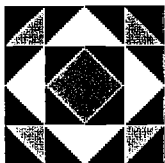
Data Research Advisory Council Presentations

November 14, 2007

- Dr. Gary Rosenthal presented to the Commissioners the findings of a Commission-sponsored study that focused on the costs of care delivered to patients who are uninsured in inpatient, ER, and ambulatory surgery settings and characterized the patient population that received such care.
- Mr. Greg Boatenhammer discussed hospital finance and cost-shifting with the Commissioners.
- Dr. Tom Evans and Dr. Marcia Ward presented to the Commissioners work the Iowa Healthcare Collaborative has done to ensure health care quality and provided recommendations to improve health care quality in Iowa.

December 19, 2007

- Dr. James Merchant presented to the Commissioners information and recommendations on health promotion in health care.
- Dr. Pete Damiano provided the Commissioners a copy of his most recent children's health insurance study.
- Dr. James Merchant provided a summary of all Data Research Advisory Council presentations.



UI College of Public Health
Healthier Workforce Center for Excellence

ATTACHMENT VI
HEALTH POLICY BRIEF

QuickTime® and a
TIFF (LZW) decompressor
are needed to see this picture.

Health Policy Brief



Health insurance and the uninsured in Iowa

Iowa ranked second among all states in a recent national comparison of health system performance by the Commonwealth Fund.¹

3-6% of children did not have health insurance in 2005; 75% of those children were eligible for either Medicaid or hawk-i.

Over 81% of uninsured adults are employed.

Underinsurance has negative health consequences due to delayed care or postponed tests and prescriptions.

Background

Health insurance coverage is one of the most important factors affecting a person's use of health care services. Iowa is in an enviable position as it considers health insurance reform. The state's 3 million residents are among the least likely to be without health insurance—the third lowest uninsured rate nationwide.²

Iowans get their health insurance from³:

- *Employer-based-60%*
- *Medicare-12%*
- *Medicaid/SCHIP-11%*
- *Individual-7%*
- *Uninsured-9%*

Latinos are over three times as likely to be uninsured as whites.

Health insurance coverage of children in Iowa

Sources of health insurance for children³:

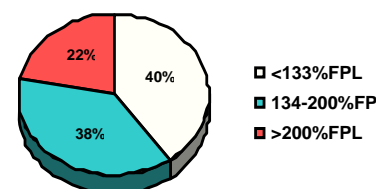
- *Employer-based-64%*
- *Medicaid/SCHIP-23%*
- *Other public-1%*
- *Individual-6%*
- *Uninsured-6%*

In 2005, an estimated 750,000 children lived in Iowa^{4,5}:

- 3-6% were without health insurance at any given time
- 4-6% with health insurance had been uninsured at some point in the previous year
- 72% with insurance were privately insured—a decline from 84% in 2000. Most with private insurance received it through an employer (92%).

Compared to children with public or private insurance, uninsured children are less likely to have a regular care provider, receive preventive care or get sick care. They are more likely to have an unmet need and visit the ER.

- Most uninsured due to related issues of high cost, lost job or lost benefits
- 3/4 of uninsured children were eligible for either Medicaid (<133%FPL) or *hawk-i* (134-200% FPL) the Iowa State Child Health Insurance Program



Health insurance coverage of adults in Iowa

Sources of health insurance for adults³:

- *Employer-based-71%*
- *Medicaid-7%*
- *Other public-2%*
- *Individual-9%*
- *Uninsured-11%*

2/3 of those without insurance were without it for more than one year

Iowa parents are more likely to consider health insurance to be 'very important' for their children than for themselves (97% v. 90%).⁴

Among uninsured adults in Iowa⁶:

- 81% are employed
- 5% are unemployed
- 14% are disabled
- 3/4 had never turned down a job with coverage

Underinsurance is an increasingly important issue and leads to:

- delayed care
- postponed tests and/or prescriptions
- changed health plans

Impact of health insurance on employers

Provision of health insurance varies by number of employees^{7,8}:

- 10-19: 74%
- 20-49: 87%
- 50-249: 94%
- 250-999: 96%
- 1000+: 100%

Iowa employers generally see value in providing health insurance:

- attract or retain employees

- keep employees healthy
- be good corporate citizens

92% say they were hurt by rising health insurance costs. For 2007:

- 77% had an increase in health insurance rates
- 48% increased employee contributions
- 26% raised deductibles

Employers recognize benefits of providing health insurance through workforce retention and improved employee health.

Policy options for covering uninsured (state-level)

Select state-level policy options are presented below by the age and situation of the population. Mandating health insurance coverage is an option for all populations with implementation strategies below:

Children: Because so many uninsured children are currently eligible for existing programs:

- decrease barriers to enrollment for the Medicaid and *hawk-i* programs
- expand eligibility for *hawk-i* beyond 200% FPL
- improve options for public coverage of specific services (e.g., behavioral-emotional health and dental care)

Young adults: Adults 18-30 have a high rate of being uninsured because they may not gain insurance through their employer as they leave their parents' policies.

- Mandate children's coverage until an older age (e.g., 26) at no or low cost.

Disabled adults: They have little to no ability to receive employer-based insurance yet often have difficulty qualifying for Medicaid SSI coverage

- increase Medicaid SSI income eligibility threshold

Parents of children in Medicaid:

Children are more likely to use services if parents are insured. Iowa increased parent Medicaid eligibility from 27% FPL to 58% FPL in 2006.

- Increase income eligibility for parents to 100% FPL

Other adults: Adults have fewer public insurance options:

- risk pool options such as the Massachusetts connector model to provide lower cost options to employers and individuals
- reinsurance for high-cost employees to decrease risk for small employers
- make the IowaCare program a more comprehensive health insurance alternative

Retired adults (pre-Medicare): have fewer state options for coverage.

- National options include Medicare expansions to those 55-64.

Reasons for being uninsured vary across the lifespan; similarly, barriers to coverage and policy options differ by age group.

State-level policy options for covering the uninsured include both public and private insurance options.

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1. Cantor JC, Schoen C, Belloff D, How SKH, McCarthy D. *Aiming Higher: Results from a State Scorecard on Health System Performance*, The Commonwealth Fund Commission on a High Performance Health System, June 2007. www.commonwealthfund.org
2. Iowa Department of Public Health. *Iowa State Planning Grant: 2005 Final Report to the Secretary*. September 2005.
3. Urban Institute and Kaiser Commission on Medicaid and the Uninsured: Estimates based on the Census Bureau's March 2005 and 2006 Current Population Survey (CPS: Annual Social and Economic Supplements). www.statehealthfacts.org
4. Damiano PC, Willard JC, Borst J, Dhooge L, Hageman G, Kane D, Penziner A. *The 2005 Iowa Child and Family Household Health Survey: Statewide results*. October 2005. <http://ppc.uiowa.edu/health/ICHHS/iowachild2005/ichhs2005.htm>
5. Damiano PC, Willard JC, Momany ET, Tyler MA, Schor E, Hageman MA, Lobas J, Penziner A, Khal B. *The 2001 Iowa Child and Family Household Health Survey: Statewide results*. October 2001. <http://ppc.uiowa.edu/health/ICHHS/iowachild2000/ichhs2000.htm>
6. Iowa Department of Public Health. *Iowa State Planning Grant: Final Report*. October 2001
7. David P. Lind & Associates. *2007 Iowa Employer Benefits Study*. 2007
8. Kinzel A. *What a drag it is: The Economic Impacts of Rising Health Insurance Premiums*. July 2004

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Other research reports are available for download or can be ordered from our Website: <http://ppc.uiowa.edu>

ATTACHMENT VII

2007 Iowa Acts, Chapter 218, section 99

107 24 Sec. 99. LEGISLATIVE SERVICES AGENCY == LEGISLATIVE
107 25 COMMISSION ON AFFORDABLE HEALTH CARE PLANS FOR SMALL
107 26 BUSINESSES AND FAMILIES APPROPRIATION. There is appropriated
107 27 from the health care trust fund created in section 453A.35A to
107 28 the legislative services agency for the legislative commission
107 29 on affordable health care plans for small businesses as
107 30 enacted by this Act, for the fiscal year beginning July 1,
107 31 2007, and ending June 30, 2008, the following amount, or so
107 32 much thereof as is necessary, for the purpose designated:
107 33 For carrying out the duties of the commission and the
107 34 health care data research advisory council:
107 35 \$ 500,000
108 1 Of the amount appropriated in this section, a portion shall
108 2 be used for the health and long-term-care workforce review to
108 3 be conducted by the department of public health as described
108 4 in this Act.

Attachment VIII

Mr. Bruce Feustel

Mr. Feustel has worked in or for state legislature for 32 years. He currently is a Senior Fellow in the Legislative Management Program of the National Conference of State Legislatures (NCSL), where he provides training and educational programs for legislators and legislative staff employees and participates in management studies of legislatures and legislative staff organizations. He has organized and taught at committee chair and new legislator training seminars, provided skill training for staff, produced compact discs and audiotapes on "How to be an Effective Legislator," provided staff support to NCSL's Legislative Effectiveness Committee and made presentations on communication, change, facilitation, and ethics. Mr. Feustel also teaches and organizes seminars on bill drafting and the legislative process, including seminars held in Algeria, Azerbaijan, Belarus, Bosnia and Herzegovina, Ghana, Indonesia, Kazakhstan, Kyrgyzstan, Mongolia, Montenegro, Poland, Romania, Russia, Tajikistan, and Uzbekistan. Until September 1995 he was an assistant chief counsel with the Wisconsin Legislative Reference Bureau. Mr. Feustel began his service at the bureau in 1974 after graduating from the University of Wisconsin Law School. He drafted legislation and provided legal advice in the areas of criminal law, corrections, and courts and procedures. He also supervised and trained new staff members.

Facilitation Notes — Mr. Feustel:

- Has facilitated strategic planning and consensus-building meetings and projects with state legislatures or committees in Minnesota, Oklahoma, Oregon, Texas, Washington, Maine, Colorado, Wisconsin, and New Mexico, and with Navajo and Osage Nation legislative bodies.
- Serves on the board of directors of CDR Associates, an organization that provides conflict resolution services nationally and internationally (www.mediate.org).
- Serves as a volunteer facilitator for weekly meetings for domestic abuse victims.

The National Conference of State Legislatures

The NCSL was founded in 1975 with the conviction that legislative service is one of democracy's worthiest pursuits. The NCSL is a bipartisan organization that serves the legislators and staffs of the nation's 50 states, commonwealths, and territories. The NCSL provides research, technical assistance, and opportunities for policymakers to exchange ideas on the most pressing state issues. The NCSL is an effective and respected advocate for the interests of state governments before Congress and federal agencies.

Mission and Governance. The NCSL is governed by a 60-member executive committee, composed of legislators and legislative staff members who are elected annually. Seven officers direct the overall work of the conference.

Services Overview. The NCSL helps state policymakers advance their ideas, provides a forum for the exchange of ideas from other states, and takes the best ideas from America's state legislatures to Capitol Hill.

How to Get involved. There are many ways to get involved with NCSL.

NCSL Standing Committees. The NCSL Standing Committees allow legislators and staff to benefit from the experiences of other states in shaping public policy, experimenting with new laws, and managing the legislative institutions. They also consider NCSL policy positions and guide NCSL's lobbying efforts in Washington, D.C.

NCSL Foundation. The NCSL Foundation for State Legislatures offers opportunities for businesses, national associations, and unions seeking to improve the state legislative process and enhance NCSL's services to all legislatures.

ATTACHMENT IX
Work Group Reports

The Commission requested assistance from the National Conference of State Legislatures (NCSL) to facilitate its meetings. Mr. Bruce Feustel was assigned to the Commission and facilitated each of the last seven meetings. With his leadership, the Commission divided into six work groups and examined issues, identified the challenges or problems, and deliberated for five months on the work group recommendations. At each Commission meeting, beginning in Mason City in August 2007, the Commission received a detailed briefing of the scope and progress of the six work groups. At its December meeting, the Commission voted on each work group's recommendations and in the spirit of legislative deliberations, changes were made to the work groups' reports. No work group report received unanimous support; however, each report received a majority vote and the reports are included as an appendix to the final report.

Work Group 1 Report
Workforce Shortages

Members:

Ms. Sarah Swisher, Chairperson
Mr. Tom Newton

Goal: Increase the number of physicians and other health care professionals living and practicing in Iowa.

Action steps

- Create tax incentives for medical students and other health and long-term care professionals to stay in Iowa.
- Establish a loan repayment program for health professionals who agree to live and practice in Iowa for a specified time.
- Place physicians into the workforce as soon as possible after completion of residency by mandating insurance companies to retroactively pay for physician services rendered between the first day of employment at the health care facility and receipt of license and credentials.

Goal: Increase the number of psychiatric residents in Iowa.

Action step

- Make a specific appropriation to fund psychiatric residencies at qualified hospitals in Iowa in addition to the slots at the University of Iowa. The appropriation should be available only to residents and institutions agreeing to practice in Iowa for a specified time.

Goal: Create extenders for the provision of psychiatric services in Iowa by allowing advanced registered nurse practitioners (ARNPs) to render psychiatric services to patients with less supervision by physicians.

Action steps

- Enact liability reform for supervision of midlevel psychiatric practitioners by physicians through legislation that lessens the circumstances under which physicians are required to sign off on the services rendered by psychiatric ARNPs.
- Allow for reimbursement of ARNPs for psychiatric services provided to Medicaid recipients.

Goal: Address workforce shortages, where appropriate, through the use of telemedicine and other technology.

Action steps

- Examine existing practices for Iowa's publicly funded health coverage programs (Medicaid, hawk-i, IowaCare) to verify that services provided through telemedicine are reimbursable, even to providers performing those services from out of state.
- Support technology infrastructure that facilitates or improves the ability to provide services through telemedicine.

Goal: Address workforce shortages, where appropriate, via the consideration of scope of practice changes.

At a time when the health and long-term care arena is experiencing increasing demand for services and a stable or declining supply of health and long-term care workers, efforts need to be

made to ensure that every worker is using his/her knowledge, skills, and abilities to the maximum extent possible.

Action step

- Review by the Department of Public Health, in conjunction with health and long-term care providers, workers, licensing boards, and others, of the opportunities to enhance the efficiency and effectiveness of the workforce via changes to scope of practice.

(Any changes to scope of practice would, of necessity, require appropriate training and appropriate compensation for the responsibilities possessed.)

Goal: Provide adequate and affordable health care coverage options for all health and long-term care workers.

Twenty-five percent of certified nurse aides in Iowa are uninsured. It is estimated that another 25 percent (or more) are underinsured. What are the results? They do not get necessary preventive care, go to the doctor when they should, or get the prescriptions filled that would help them manage and maximize their health. They also go to work sick, risk giving to others what they have, and undermine the quality of care for, and the health of, those they serve.

Certified nurse aides are not the only health and long-term care occupations affected by the lack of adequate and affordable health insurance. Multiple occupations, just within the direct care profession (those who serve the health and long-term care needs of Iowa's aging and disabled population) are similarly situated.

Action step

- The workforce subcommittee strongly believes that the health and long-term care workforce (due to the nature of the work they do, the fragility of those they serve, and the need for health coverage to serve as a valuable recruitment and retention tool), should be viewed as one of the highest priority groups to be covered by adequate and affordable health insurance, and that any legislation drafted to implement universal or near universal coverage for Iowans should be built upon that recognition.

Goal: Create an office and advisory council charged with conducting ongoing health workforce assessment and planning in Iowa.

Action steps

- Establish an Office of Health Workforce within the Department of Public Health to help assure a competent, diverse, and sustainable health workforce in Iowa and improve access to health care in underserved areas.
- Establish a Health Workforce Advisory Council to inform and advise the Department of Public Health, the Office of Health Workforce, and policymakers on issues relevant to the health workforce in Iowa.

Goal: Increase the wages of bedside care workers and direct care workers.

The State of Iowa and the federal government are primary payers of health and long-term care services via the Medicaid program. Nursing homes, and other providers of health and long-term care services, are often viewed as "government contractors" who provide the services, hire and pay the staff, and meet the expectations of the government.

The wages and benefits provided for bedside and direct care staff in health and long-term care services (including registered nurses) are directly related to Medicaid reimbursements. Several states are dealing with the need to raise wages/benefits as a recruitment and retention tool by considering legislative mechanisms that target a fixed percentage of provider reimbursement rate

increases for increases in staff wages and benefits. Examples include the states of Minnesota and Montana.

Minnesota, in 2007, via amendments to state statute 2006, section 256B.434, provided a rate increase to nursing facilities with this direction: "Seventy-five percent of the money resulting from the rate adjustment under paragraph (a) must be used for increases in compensation-related costs for employees directly employed by the nursing facility...", and further stated that those increases would be specified for nonadministrative and nonmanagement contract staff.

Similarly, the 2007 Montana Legislature approved a \$2.6 million Medicaid rate increase for providers of personal assistance services solely to be used by those agencies to purchase health insurance for direct care workers. In addition, legislation was passed that required the Department of Public Health and the Department of Human Services to study the feasibility of implementing a similar health insurance designated rate increase for workers who provide direct care services in other long-term care settings.

These examples illustrate that Medicaid dollars can be and are being used to target specific employee populations that have specific needs related to recruitment and retention.

Action step

- Any increases to Medicaid reimbursement rates should also support wage increases for bedside care workers and direct care workers.

Goal: Credential the long-term care workforce in Iowa.

Action step

- In December 2006, the Direct Care Worker Task Force released recommendations to improve education and training for Iowa's direct care workforce. One of the recommendations was to establish a governing board within the Department of Public Health to provide accountability and oversight of certification and impose professional standards. During the 2007 Legislative Session, funding was appropriated to the department to implement the recommendations contained in the report. The Commission recommends that the Legislature authorize the department to establish a certification board for direct care workers within the Bureau of Professional Licensure.

Goal: Provide whistleblower protections for health and long-term care workers in the private, nonprofit sector.

Whistle blowing by nurses usually results from concern about issues that jeopardize the health or safety of patients or occupational safety and health violations that place the employee at risk. Yet, even though nurses are responsible for patient care and well-being, nurses are often powerless when another health care provider performs unethical or life-threatening practices. Retribution and dismissal for whistle blowing are not uncommon. In fact, there have been a number of legal cases involving nurses who have been retaliated against for "blowing the whistle" on their employers.

Current whistle blowing laws remain a patchwork of incomplete coverage. For example, the False Claims Act contains a whistleblower provision that applies only in cases of fraud or misuse of federal funds. The Emergency Treatment and Labor Act (EMTALA) includes protections for patient advocacy, but only for personnel working in the emergency department of a hospital. The Whistleblower Protection Act of 1989 only applies to federal employees (e.g., Veterans Administration nurses). State of Iowa employees and nursing home workers have adequate coverage, but private sector hospital workers do not. This confusing, incomplete coverage leaves many nurses fearing reprisals such as dismissal, harassment, and blacklisting.

The lack of a blame-free reporting system prevents many nurses from taking the risk of trying to protect their patients' health and safety. In order to allow nurses to function as successful patient

advocates and to retain them in their field to assure a quality health care workforce in Iowa, effective whistleblower protections for nurses who report unsafe patient care must be enacted. Other Midwestern states that have whistleblower protection are Wisconsin, Minnesota, and Illinois.

Action step

- Enact legislation which provides whistleblower protections to health and long-term care workers in the private, nonprofit sector.

Work Group 2 Report
Electronic Health Records

Members:

Representative Linda Upmeyer, Chairperson
Senator Jerry Behn
Dr. Tim Kresowik

Principles and Recommendations on Health Information Technology

1. Health information technology (health IT) is rapidly evolving and advancing toward its goal of improving access to health care, improving quality of care, enhancing efficiency, and reducing costs.
2. To be effective, health IT systems must:
 - Be patient-centered and market-driven.
 - Be based on approved standards arising out of the work of the committees sanctioned by the Office of the National Coordinator and sound principles developed with input from stakeholders.
 - Protect the privacy and security of all health information.
 - Promote interoperability.
 - Ensure the accuracy, completeness, and uniformity of data.
3. Widespread adoption of health IT — critical to its success — can be best achieved when:
 - The market provides users a variety of certified products from which users can choose the one that best fits their needs.
 - There are incentives for health care providers to adopt the use of health IT and rewards for those providers who improve quality and efficiency through using health IT.
 - There are protocols for addressing critical problems such as unauthorized disclosure of protected health information and inaccurate or incomplete data.
 - The systems are financed by all who benefit from the increased quality, efficiency, savings, and any other benefits that result from health IT.

Goal #1: To make Iowa the national leader in the development and use of technology to utilize electronic health records and telemedicine systems.

Goal #2: To utilize the aggregated data collected to improve the health provided to Iowans.

Goal #3: To support efforts to lower health care costs, increase quality care, and increase the likelihood of achieving universal access to health care, the state will establish a statewide network to transfer health care information in a secure and reliable environment by using one or more dedicated fiber optic systems.

Goal #4: To utilize telehealth and telemedicine technology in the care of patients needing access to specialty care, particularly in areas underserved by medical providers.

Commission Proposal #1: Establish the Iowa eHealth Council

- Create a statewide governing and oversight public/private Iowa eHealth Council in the Department of _____ to oversee the development and implementation of electronic health records, telehealth, and other electronic health initiatives.
- The Iowa eHealth Council shall be comprised of seven individuals with broad experience and vision in health care and health technology and at least one member

who will represent the consumer. The original appointees will be made in collaboration between the Governor's Office, Chairpersons of the Legislative Health Commission, and the Chairperson of the EMR workgroup of the commission with Senate confirmation. Thereafter, the Governor will appoint with Senate confirmation.

- Ex officio members would include:
 - Four legislators representing one from each caucus.
 - Directors of Department of Public Health, Department of Human Services, and the Iowa Communications Network.
- Duties of the council:
 - Oversee the state's involvement in the Iowa Health Systems and Iowa Hospital Association networks systems including promulgating rules, effectuating completion of the networks, and resolving any disputes, in addition to making recommendations for improvement over time.
 - Appoint an Iowa eHealth Council director with some administrative assistance who will have duties including but not limited to oversight of the state's day-to-day involvement with health IT networks, perform varied tasks including troubleshooting and testing the system, and measurement of utilization and mediation of disputes.
 - Participate in the creation of a memorandum of understanding among the Iowa Communications Network, Iowa Hospital Association, Iowa Health Systems, and all other entities who will eventually be connected to the networks. Obtain sign off from as many as possible in 2008.
 - Establish protocols to ensure that the privacy of the patient is protected and systems are secure.
 - Establish protocols necessary to conform to federal standards.
 - Work with the Iowa Communications Network to make available such bandwidth on the network as may be needed by Iowa providers (not limited to hospitals, physicians, long-term care centers, pharmacies and dentists), and state (Medicaid services), federal (Medicaid and Medicare), and insurers for so long as said bandwidth may be needed.
- Utilize funds appropriated in support of health IT initiatives in the state, including support for infrastructure and operational needs.
- Calculate payments to be made by each provider to access the networks so that it can operate without state subsidy and at cost.
- Require a usage study on the operation of the networks to determine if and how the networks reduce expenditures for paper and other filing systems and increases efficiency and time management within the facilities.
- Assess the University of Iowa Hospitals and Clinics' and Broadlawns Medical Center's level of preparedness for the transition to an interoperable electronic environment.
- Seek and apply for any existing federal or private grant funds that will assist in the establishment of the system.
- Educate Iowans about electronic health records and telehealth/telemedicine possibilities and benefits.

Commission Proposal #2: The Iowa eHealth Council is directed to consider the following issues in implementing telehealth and telemedicine proposals in 2009

- Consider telemedicine procedures in providing access to direct provision of clinical care via telecommunications — diagnosing, treating, or managing a patient at a distance in specialties including but not limited to psychiatry, internal medicine, rehabilitation, cardiology, pediatrics, obstetrics and gynecology, and neurology.
- Examine existing barriers to the creation of effective telehealth programs.
- Examine the most efficient and effective systems of technology for use, including consideration of store and forward, a digital image (stored) and then sent (forwarded) by computer to another location; and two-way interactive television used when a face-to-face consultation is necessary.

Commission Proposal #3: Implement a fully capable e-prescribing plan for Iowa

- Seek the input of pharmacists and all medical providers, hospitals, and state and federal Medicaid, Medicare, IowaCare, and VA systems to have a statewide, fully utilized system by 2010.

Commission Proposal #4: Coordinate with the Department of Public Health's information technology workforce needs

- Seek the input of the community colleges and regents universities to address workforce needs to carry out the initiatives of the Iowa eHealth Council.

Work Group 3 Report
Medical Home

Members:

Representative Ro Foege, Co-chairperson
Dr. David Carlyle, Co-chairperson
Mr. Kevin Concannon
Mr. Jay Christensen
Dr. Steve Fuller
Ms. Barb Kniff

Goal: To reduce costs and increase quality care, every lowan should have a patient-centered medical home which emphasizes preventive care, wellness programs, and chronic disease management.

- I. **Definition of medical home.** The definition of medical home is based upon the American Academy of Family Physicians' patient-centered medical home concept. The subcommittee recommends replacing the word physician with provider. The new definition is:
1. **Personal provider** — each patient has an ongoing relationship with a personal provider trained to provide first contact, continuous, and comprehensive care.
 2. **Provider-directed medical practice** — the personal provider leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
 3. **Whole person orientation** — the personal provider is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life, acute care, chronic care, preventive services, and end-of-life care.
 4. **Care is coordinated and/or integrated** across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchanges, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.
 5. **Quality and safety are hallmarks of the medical home**
 - Medical practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between providers, patients, and the patient's family.
 - Evidence-based medicine and clinical decision-support tools guide decision making.
 - Providers in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
 - Patients actively participate in decision making and feedback is sought to ensure that patients' expectations are being met.
 - Health IT is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.
 - Practices go through a voluntary recognition process by an appropriate nongovernmental entity to demonstrate that they have the capabilities to provide patients centered services consistent with the medical home model.
 - Patients and families participate in quality improvement activities at the practice level.

6. Enhanced access to care is available through systems such as open scheduling, expanded hours, and new options for communication between patients, their personal providers, and practice staff.

7. Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

- It should reflect the value of provider and nonprovider staff patient-centered care management work that falls outside of the face-to-face visit.
- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
- It should support adoption and use of health IT for quality improvement.
- It should support provision of enhanced communication access such as secure e-mail and telephone consultation.
- It should recognize the value of physician work associated with remote monitoring of clinical data using technology.
- It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits.)
- It should recognize case mix differences in the patient population being treated within the practice.
- It should allow providers to share in savings from reduced hospitalizations associated with provider-guided care management in the office setting.
- It should allow for additional payments for achieving measurable and continuous quality improvements.

II. Purposes — a patient-centered medical home emphasis serves two purposes

- Having a patient-centered medical home is a tangible method to document if a given Iowan truly has access to health care.
- It is believed that the use of certified patient-centered medical homes improves quality and lowers health care costs. Widespread, if not universal, use of certified patient-centered medical homes will create health care savings that will allow more Iowans to be insured and, further, will improve the possibility that our proposed actions are sustainable.

III. Commission proposal — creation of the Iowa Medical Home Board to determine the qualifications for, and certify, a patient-centered medical home. The board will be under the direction of the Department of Public Health

- 1. Improving quality and reducing health care costs — certifying a medical home:**
 - For the expressed and only purpose of improving quality and lowering health care costs, Iowa will adopt a process to certify patient-centered medical homes. It is anticipated that this process will utilize the upcoming National Committee for Quality Assurance's standards to certify patient-centered medical homes, in whole or near total, based on a review by the Iowa Medical Home Board. The group considered similar standards proposed by the Department of Public Health and Dr. Carlyle.
 - Iowa will encourage, promote, and, if possible, fund efforts to transform medical practices into certified patient-centered medical homes with special emphasis on such practices implementing electronic medical records.
- 2. Education and training standards.** The board will provide suggestions for specific education and training standards for providers of a medical home. The board will work with the University of Iowa Hospitals and Clinics, Des Moines University, Mercy College, and others. (Certification for uniform implementation.)

3. Incentives for providers. The board will suggest incentives to become a certified patient-centered medical home. The board will analyze at least the following criteria when determining potential incentives and is required to look at the financial feasibility of any incentive:

- Items not reimbursed for Medicaid by the Department of Human Services to promote wellness and prevention of chronic disease management.
- Increase rates to Medicare levels for certain wellness, prevention, chronic disease management services, and immunizations.

4. Iowa Medical Home Board membership. The director of the Department of Public Health will head the Iowa Medical Home Board. The other members of the board may include the director of the Department of Human Services, the Iowa Insurance Commissioner, consumers, providers, legislators, and others.

IV. Commission proposal — implementation and oversight

1. Programs under the State of Iowa. Iowa will, where possible, pay certified patient-centered medical homes to care for patients under its authority, e.g., Medicaid, hawk-i, the IowaCare Program, state employees, and any new insurance pool created by the Commission.

2. Other Programs. Iowa will work with other insurance entities and self-funded companies to create a multipayer effort to pay certified patient-centered medical homes for care of patients utilizing common certifying and reporting mechanisms. Iowa will work with Medicare directly or via a Medicare advantage route to allow Medicare patients to utilize this common certified patient-centered medical home project.

3. Oversight of Medical Home. The board will have oversight over all certified patient-centered medical homes. The board will meet quarterly to review the progress of the certified medical home program and implement changes to improve the program.

4. Evaluation. The board will develop a plan to evaluate the effectiveness of a certified patient-centered medical home. The board will solicit information from all payers for medical homes, including but not limited to Medicaid and private insurers. The information should compare if quality has increased and if costs decreased for patients participating in a medical home versus patients not participating in a medical home.

If, after a five-year review of this certified patient-centered medical home project it is determined that either quality was not improved and/or health care costs were not reduced, then the board will make a recommendation to the State of Iowa regarding its continuation.

V. Commission Proposal — I-Smile, Dental Home

Strengthen language in the Code for the I-Smile, Dental Home (Code section 249J.14(7)) Program to enforce comprehensive dental care for children 12 years of age and younger. Proposed changes would set a minimum standard equal to the Early and Periodic Screening, Diagnostic, and Treatment Services. In addition, the board will review the feasibility of financial incentives to dentists and nondental providers to promote oral health coordination through preventive dental intervention, treatment, chronic disease management, education, parental guidance, and oral health promotions for children.

Work Group 4 Report
Health Care Coverage

Members:

Senator Jack Hatch, Chairperson
Representative Clarence Hoffman
Mr. John Aschenbrenner
Ms. Susan Voss
Mr. Russ Sporer
Ms. Janice Laue
Mr. Kevin Concannon

Goal #1: To lower health care costs and to ensure greater access to health care.

Goal #2: To require that all lowans have health care coverage that meets certain minimum requirements and is affordable.

Goal #3: To provide subsidized health care coverage to low-income lowans who presently do not have health care coverage, especially children, families, and employees of small businesses with less than 50 employees.

Goal #4: To protect high-risk lowans from excessive, out-of-pocket costs; provide a mechanism for making mandatory participation in insurance coverage as easy as possible; ensure that each individual has a guaranteed source for purchasing coverage; ensure administrative costs associated with delivering subsidies are kept as low as possible; and, critically, identify sufficient sources of financing.

The challenges

- Iowa has the third lowest uninsured rate in the United States and is ranked second among all states in a recent national comparison of health system performance. However, it is estimated that approximately 9 percent of the state's 3 million residents are uninsured. The challenges include:
- **Uninsured children.** In 2005 an estimated 750,000 children lived in Iowa and 3-6 percent of those children were uninsured at any given time. Approximately 75 percent of the uninsured children were eligible for either Medicaid or hawk-i, the Iowa State Child Health Insurance Program (SCHIP), but were not enrolled.
- **Uninsured adults.** Approximately 13 percent of Iowa's adults aged 19-64 are uninsured. In addition, 81 percent of uninsured adult lowans are employed, and many work two or more jobs. Of the remainder, 14 percent are disabled and 5 percent are unemployed. Uninsured adults typically earn low wages, with 60 percent of them earning less than \$30,000 per year.
- **Uninsured pre-Medicare adults.** Uninsured adult lowans who are near-seniors aged 55-64 face unique challenges that other uninsured adults may not face. If they retire early or lose their jobs while they are not yet eligible for Medicare, they may have few options for coverage because of their age and preexisting conditions and the coverage that is available may be very expensive.
- **Uninsured young adults.** Uninsured young adults aged 19-25 are sometimes referred to as "the invincibles." These young adults may be uninsured because they have aged out of their family's health insurance coverage or public health coverage and either cannot afford or do not see a need to purchase health insurance. Although health care costs of this age group are generally relatively low, they also have the highest incidence of accidents, and the cost to provide them with public or uncompensated care is increasing each year.
- **Uninsured employees of small businesses.** The vast majority of uninsured adult lowans work for small businesses with less than 50 employees and many with less than 10 employees. The small business workforce generally has lower wages than that of larger employers. Small businesses face disadvantages relative to large employers in

providing health insurance to their employees. The smaller size of their groups results in higher administrative costs of insurance and limited ability to spread health care risk, which in turn necessitates higher premiums, adding to making the insurance unaffordable for both the small businesses and their employees. As a result, only 36 percent of businesses with fewer than 10 employees offer health insurance to any of their workers, compared with 94 percent of businesses with 50-249 employees and 100 percent of businesses with 1,000 or more employees. Only about 46 percent of employees of small businesses with less than 10 employees are offered and eligible for enrollment in their employer's health insurance plan, compared with 88 percent of workers employed in businesses with 100 or more employees. Workers in the smallest businesses are also less likely to accept employer offers of health insurance than their large business counterparts, although some of these employees may receive coverage through a spouse who is employed by a larger business.

- **Large employers.** Rapidly escalating costs of health care are also creating difficulties for larger businesses and their employees. Employers are often increasing deductibles and co-pays or otherwise reducing benefits in an effort to slow down their increasing costs, putting an added burden on their employees. While Iowa has not yet had a significant number of large employers terminating their health insurance coverage, this may well be the result in the future if health care and health care coverage costs continue to escalate at their current pace.

The Recommendations

I. Commission proposal #1 — all Iowans will have health care coverage that meets certain minimum requirements and is affordable. Iowa should move as quickly as possible to achieve this goal by

A. Maximizing the use of existing federally supported health care coverage with the following priorities

1. Cover all children eligible for Medicaid and hawk-i by July 1, 2009.
2. Cover parents of Medicaid and hawk-i eligible children.
3. Continue to expand options for individuals who are dually eligible for Medicare and Medicaid (typically the chronically disabled) by utilizing evidence-based care.

B. Maximizing the use of state and private financial support with the following priorities

1. Begin providing health care coverage to all remaining children and adults.
2. Provide sliding-scale, subsidized coverage to low-income, uninsured individuals and families with incomes below 300 percent of the FPL equivalent to the SCHIP coverage presently provided through the hawk-i program, as funding becomes available.

C. Progressing toward a requirement that all Iowans have health care coverage that meets certain minimum specifications

1. Iowans who can afford health care coverage must purchase it themselves either directly through the private insurance market or through the new Health Care Exchange.
2. Iowans who cannot afford to purchase health care coverage will receive state funding/subsidization to purchase coverage through the new Health Care Exchange or through a plan provided by an employer.

D. Ascertaining the true costs of achieving universal health care coverage in Iowa

1. The Commission currently has insufficient data to know the true costs of achieving universal health care coverage. All Iowans now have access to immediate health services. Unreimbursed care is often provided in the most expensive manner (hospital emergency rooms and at advanced stages of disease/injury). These expenditures are buried in the system.
2. The Commission needs a methodology to take the dollars already being spent and use them in a more effective and efficient manner.
3. To understand the true economics of achieving universal health care coverage in this state, the following steps should be initiated in 2008:

- Define the minimum specifications for health care coverage plans that balance desires for flexibility, affordability, and comprehensiveness by:
 - Covering wellness, prevention, and diagnosis.
 - Covering catastrophic expenses.
 - Providing a reasonable level of basic care.
 - Including prescription drugs.
- Define parameters for affordability and levels of subsidization of private insurance premiums by:
 - Creating an affordability schedule that is conservative to prevent harm to people who are struggling financially and that utilizes a progressive scale of decreasing subsidization as incomes increase.
 - Requiring people with very low incomes to pay only small amounts toward health care coverage with no financial penalties. Research shows that many low-income people struggle to pay for basic necessities and are likely to have negative cash flow. In Massachusetts, studies indicate that families with incomes below 300 percent of FPL may not have enough earnings to cover even basic needs.
 - Setting the upper bound of affordability at about 8.5 percent of income, including consideration of assets held. Data shows that people with higher incomes can reasonably afford health insurance at that level of contribution. People with unsubsidized, nongroup premiums currently pay an average of 8.5 percent of their income on health insurance.
- Commission a study to determine the costs to achieve this goal and the potential moneys that might be available through various funding strategies such as general tax revenues and other special revenue funds; tobacco taxes; premium payments by insureds; maximizing federal dollars; demonstrated cost controls; health insurer assessments (including self-funded plans); assessments of hospitals, health providers, and medical equipment; and junk food and other creative assessments.
- Encourage, but not require, employers to participate in providing and partially funding health insurance for their employees. Employers not participating at a minimum specified level would be required to help fund the Health Care Exchange Pool. For example, an employer who does not provide health insurance coverage to employees or who does not make contributions to health insurance for employees would be required to pay an assessment to the pool. If an employer provides insurance and makes a contribution on behalf of an employee but the coverage is still not affordable for that person, the employer would pay the amount of the contribution to the pool to assist the employee with purchasing insurance through the exchange or through the employer. The state could also subsidize an employee's purchase of insurance through a plan provided by an employer.
- Develop a process for enforcing the health care coverage requirement that could include:
 - Requiring every individual to have and report health care coverage, and failure to do so will result in assignment of that individual to a plan by the exchange.
- Requiring certain employers (who employ a specified number of employees) to provide and report minimum required health care coverage/contributions for employees and to pay an assessment for failure to do so — e.g., contributions to the Health Care Exchange Pool for cost of their employees' coverage (possible ERISA issues).
 - Monitoring health care coverage of children through school enrollment procedures.

E. Collaborating with the private insurance market

1. Assure the availability of private insurance coverage for all lowans by working with the insurance industry to design solutions to guaranteed availability/issue, preexisting condition exclusions, portability, and allowable/required pooling and rating classifications.

2. Formulate a set of principles for ensuring fair and appropriate practices for individual market policy rescission and preexisting condition clauses along with a binding third-party review process to resolve disputes related to preexisting condition exclusions and rescission decisions.

F. Establishing a transition period.

1. Transition period from July 1, 2008, to whenever Iowa has implemented effective, mandated universal coverage.

2. Prior to the time that a program is implemented that effectively ensures all lowans have health insurance coverage, establishes a plan using the high-risk pool to improve accessibility to health insurance at reasonably affordable rates for all and provides that:

- Insurers would take everyone rated up to 200 percent of standard at a maximum premium rate of 150 percent of the standard rate.
- Anyone over 200 percent of the standard rate goes into a state plan (high-risk pool) at 150 percent of standard premium rates. The state picks up the extra cost.
- There is an open enrollment period when anyone can enroll with no preexisting condition exclusion.
- Guaranteed issue insurance coverage with no preexisting condition exclusion is available for anyone moving from another health plan with no more than 63 days lapse of coverage.
 - (a-d need further explanation to be understandable to noninsurance people)

G. Providing universal coverage with no preexisting condition exclusions

Once Iowa has in place a program to effectively ensure that all lowans have health insurance coverage, health insurers will make coverage available on a guaranteed issue basis to everyone with no preexisting condition exclusions if the Health Care Exchange determines that is the best approach.

H. Pooling and Rating Classifications

1. Pooling and rating classifications will need to be determined that balance principles of equity, fairness, and cost-sharing and that best facilitate the goal of affordable coverage for all.

2. Along with other issues, these determinations would address the questions of age rating and the possible combination of individual and small group coverage.

II. Commission proposal #2 — creation of Health Care Exchange, a quasi-public/private agency, to help individuals and businesses comply with and to implement and facilitate universal health care coverage for all lowans and to lead health care quality, safety, and cost reduction initiatives

A. Board of Directors. The Health Care Exchange will be overseen by a small, workable board of directors which includes consumers, a health economist, and an actuary, who are appointed by the Governor, and subject to confirmation by the Senate. Include Director of the Department of Human Services and the Insurance Commissioner as voting members. Legislators appointed by leadership as ex officio, nonvoting members. Consider including previous governors as members.

B. Executive Director. The administrative head of the Health Care Exchange will be appointed by the Board of the Exchange, subject to confirmation by the Senate. Initial funding for the agency will be from general funds, through the Health Care Trust Fund, and later funding from the revenues in the Health Care Exchange Pool.

C. Participation. Individuals and small groups subject to the requirement to have health insurance coverage that do not select a private health insurance plan will automatically be represented by the Health Care Exchange.

D. Powers. The Health Care Exchange will have broad authority to:

1. Work with insurers to design affordable, portable health insurance plans that meet the needs of low-income populations. This might include specialized plans such as lower-cost health coverage products for 19-29-year-olds.

2. Establish, by rule, what constitutes minimum acceptable health care coverage within parameters set by statute.

3. Implement a health care coverage program called Iowa Choice Care which provides subsidized private coverage to individuals and families who do not meet eligibility guidelines for any other program, with rolling implementation expanding to specified subgroups of low-income adult lowans based on availability of funding and provides affordable, unsubsidized private coverage to anyone who desires to purchase it, including individuals, families, and employees of small businesses.

4. Administer a subsidy program for payment of premiums for health care coverage by low-income people that complements, not supplants, Medicaid, and includes cost-sharing by the insured using a sliding scale based on income, utilizing the federal poverty level guidelines. This may include subsidizing an employee's purchase of health care insurance offered by that person's employer.

5. Implement initiatives, such as uniform applications and other standardized administrative procedures, that make the purchase of insurance easier and that lower administrative costs, which may include determining an equitable administrative cost formula.

6. Implement initiatives that allow portability of insurance between employers for part-time workers who work more than one job or for people who change jobs.

7. Determine premiums by establishing rates to ensure affordability of plans offered by the Health Care Exchange.

8. Define what constitutes "affordable" health care coverage by establishing what percentage of income can reasonably be spent on health care coverage, e.g., 5 percent of income in SCHIP or an amount determined by modeling.

9. Initiate and manage programs aimed at improving quality and safety and controlling health care costs.

10. Encourage (or require) employers to offer Section 125 of the Internal Revenue Code plans which allow individuals to purchase insurance using pretax dollars, resulting in substantial savings on state and federal income and federal FICA taxes for employees and FICA withholding taxes for employers (possible ERISA issues).

11. Implement the program in accordance with a time frame established by statute. The Administrative Rules Review Committee will provide oversight regarding implementation through the administrative rulemaking process.

III. Commission proposal #3 — institute insurance reforms

A. Private insurance coverage — availability. Assure availability of private insurance coverage for all lowans by working with the insurance industry to design solutions that address the following:

1. Guaranteed availability/issue.
2. Preexisting condition exclusions.
3. Portability.
4. Allowable/required pooling and rating classifications.

B. Insurance reforms. Insurance reforms should include:

1. A set of principles for ensuring fair and appropriate practices for individual market policy rescission and preexisting condition clauses along with a binding third-party review process to resolve disputes related to preexisting condition exclusions and rescission decisions.

2. Prior to the time that Iowa implements a program that effectively ensures all lowans are covered by health insurance, implement a plan using the high-risk pool to improve accessibility at reasonably affordable rates for all.

3. Insurers would take everyone rated up to 200 percent of the standard at a maximum premium rate of 150 percent of the standard rate.

4. Anyone over 200 percent of standard goes into a state plan (high-risk pool) at 150 percent of standard premium rates. The state picks up the extra cost.

5. There is an open enrollment period(s) when anyone can enroll with no preexisting condition exclusion.

6. Guaranteed issue with no preexisting condition exclusion is available for anyone moving from another health plan with no more than 63 days lapse of coverage.

C. Guaranteed issue. Once Iowa has in place a program to effectively ensure that all lowans are covered by insurance, health plans will make coverage available on a guaranteed issue basis to everyone with no preexisting condition exclusions.

D. Use of pooling and rating classifications. Pooling and rating classifications will need to be determined that balance principles of equity, fairness, and cost-sharing and that best facilitate the goal of affordable coverage for all. Along with other issues, the questions of age rating and the possible combination of individual and small group coverage should be considered.

E. Coverage of young adult dependents

1. Require insurance policies to provide coverage under group health plans to dependents up to age 25 at an appropriate premium.

2. Consider this requirement from a cost perspective as well as from the perspective of providing insurance coverage to some of the young adult uninsured lowans.

Work Group 5 Report
Iowa Health and Wellness Strategies

Members:

Representative Mark Smith
Ms. Julie Kuhle
Ms. Amy DeBruin

Goal: To contain costs, provide quality health care services, and reduce disparities by creating a wellness coalition whose members would agree upon common principles that would guide and influence supply and demand for health care services in Iowa.

I. Background

As health care costs continue to escalate, incentives and education need to drive individual responsibility for use of health care services and for lifestyle choices that improve health while containing costs. A health and wellness strategies consortium would serve as a catalyst to advance voluntarily adopted strategies to improve quality of care, availability of services, and contain costs if legislation did not support mandates related to health care coverage.

II. Commission proposal — create the Iowa Health and Wellness Strategies Consortium

The Legislature will establish and fund for one year an Iowa Health and Wellness Strategies Consortium to discuss, direct, and implement best practice models within Iowa's health care system.

The Legislature will charge the Iowa Health and Wellness Strategies Consortium to agree upon common principles that will guide and influence supply and demand for health care services in Iowa with the goals of providing quality health care services, increasing access to services, reducing disparities, and containing costs while emphasizing population health and wellness.

During the second year, the Legislature will partially fund the Iowa Health and Wellness Strategies Consortium. The consortium will also be partially funded by membership dues, in-kind contributions, and grants during the second year and will be fully funded by membership dues, in-kind contributions, and grants thereafter.

The Legislature will determine core membership for the Iowa Health and Strategies Wellness Consortium during the first two years. The consortium will determine expanded membership and dues structure during the first year. Core members of the consortium will include representatives from purchasers, payers, and providers of health care, including but not limited to representatives from the Department of Human Services, Department of Public Health, the Department of Administrative Services, the Iowa Health Buyers Alliance, Wellmark, Principal, small businesses, and labor unions.

III. Commission proposal — direct health and wellness strategies

The Legislature will oversee the Iowa Health and Wellness Strategies Consortium during the first year through biannual progress reports. The consortium will focus their discussion and activities on three key issues:

1. Implementing initiatives that promote wellness.
2. Directing and promoting adoption of strategies to contain health care costs.
3. Increasing the public's role and responsibility in their health care choices and decisions.

The consortium should direct the following strategies for health care payers and purchasers to promote or adopt:

1. Initiatives that promote wellness:
 - Providing a smoking cessation program a standard benefit, including reimbursement for treatment and support services.
 - Providing obesity prevention services in a standard health care benefit.
 - Increasing immunization rates for pneumococcal and influenza. Approving an administration fee for all qualified providers of flu and pneumococcal vaccinations.
 - Providing incentives (e.g., reduced physician office co-pays) to members participating in wellness programs.
2. Strategies to contain health care costs:
 - Promoting adoption of health IT through provider incentives.
 - Considering a four-tier prescription drug copayment system within prescription drug benefits that includes a zero co-pay tier for select medications to improve patient compliance.
 - Providing a standard medication therapy management program with prescription drug benefits to optimize high-risk patients' medication outcomes.
 - Investigating whether pooled purchasing for a prescription drug benefit (common statewide preferred drug list) would decrease costs.
 - Other strategies as determined by the consortium.
3. Increase the public's role and responsibility in their health care choices and decisions:
 - Creating a public awareness campaign to educate consumers on smart health care choices and promoting value-based purchasing.
 - Promoting public reporting of quality and performance measures that support a value-based purchasing system.

Addendum:

On 12/13/07 a teleconference was held and the following addendum was developed.

A possible strategy is to implement the recommendations outlined above in a pilot program using groups with state-funded health benefits. The General Assembly could implement these recommendations in plans funded partially or wholly by state money such as Medicaid, State of Iowa employee group health plans, and possibly regents institutions health care plans. These efforts would need to be consistent with collective bargaining agreements in effect.

Work Group 6 Report
Patients' Rights/Cost Containment/Funding

Members:

Senator Joe Bolcom, Chairperson
Senator Amanda Ragan
Senator Larry McKibben
Representative Elesha Gayman
Mr. Eric Parrish
Mr. Joe Teeling
Ms. Patsy Shors
Ms. Sharon Treinan
Ms. John McCalley

Goal #1: To make health care coverage more affordable.

Goal #2: To provide broadly available and easily accessible information about health care providers' quality and price information.

The Problem

Cost containment and funding are two of the most important elements in creating universal health care access that is economically sustainable. Without meaningful cost containment strategies, any expansion of coverage to uninsured lowans will be difficult to sustain over time. Moreover, increased funding to meet the health care coverage needs of low-income lowans is finite. Therefore, any new investment must be done as cost effectively as possible.

We believe in and endorse the four cornerstones of health care: interoperable health information, transparency of quality information, transparency of price information, and incentives to promote high-quality and cost-effective care.

Cost containment in the health care system has been elusive. The strategies below include both long-term and short-term approaches to improve access to health care coverage. We also believe that a population-based approach to greatly improving the health status of lowans by investing far more in antismoking initiatives and health promotion efforts that focus on eating smarter and exercising more is essential.

One long-term cost containment strategy focuses on prevention and management of chronic diseases. Chronic diseases such as heart disease, stroke, diabetes, and cancer are among the leading causes of disability and death in the United States. Chronic diseases account for 70 percent of deaths and about 78 percent of health spending. While there has been some success in employer-based programs and a few community efforts, population-based efforts have been more difficult.

Another focus of cost containment should be to do a better job of eliminating duplication and unnecessary expenditure on facilities and equipment by scrutinizing every major expansion of facilities and technology. We believe that the certificate of need process needs to be strengthened and more expertise needs to be directed to this effort. In addition, we believe that a Health Insurance Consumer Advocate is needed to investigate the legality of all rates, charges, rules, regulations, and practices of all persons under the jurisdiction of the Insurance Division.

The Recommendations

1. Commission Proposal — Increase public health wellness/prevention/health promotion efforts.

A. Remove unhealthy food from schools.

- Create the HealthVend Program, a revolving school loan program that will allow schools to purchase vending machines that carry only healthy foods.

- Improve school lunches to provide more fruits, vegetables, and lean meats.
- B. Improve the health of Iowa's children by enacting the Healthy Kids Act of 2008 as proposed by the healthy children coalition (draft language available).**
- Provide adequate funding for and encourage all children to get the full schedule of childhood and adolescent immunizations.
 - Set physical activity guidelines for Iowa's schools.
 - Encourage wellness among students, including well-child screenings.
- C. Encourage more Iowans to quit smoking.**
- Implement a statewide ban on workplace smoking.
 - Expand smoking cessation programs.
 - Allow local regulation of workplace tobacco use.
- D. Encourage physical activity for seniors.**
- Work with the Department of Elder Affairs and the Department of Public Health to expand physical activity programs for Iowa's seniors in collaboration with Senior Corp and RSVP for Iowa Seniors.
 - Direct the Department of Elder Affairs and the Department of Public Health to form strategies and partnerships with provider and consumer stakeholders to promote voluntary, community-based physical activity programs for older Iowans.
- E. Promote wellness efforts among Iowans.**
- Encourage Iowans to get regular health screenings, including mental, dental, cancer, and other preventative steps and work with the Department of Public Health to connect them to those services.
 - Create a wellness web site where individuals can learn about successful wellness efforts across the state, and create their own personal wellness plans, including information on healthy eating, physical activity, and health screenings.
 - Support the Department of Public Health to promote wellness efforts.
 - Wellness grants (building on the success of the Harkin Grants) to local boards of health for programs that focus on increased physical activity and improved nutrition.
 - Increase the capacity of Iowa's local boards of health and local public health agencies to plan and deliver public health services that will improve the lives of Iowans.
- 2. Commission proposal — support healthy local food consumption in Iowa.**
- A.** Increase local food purchases by the state at institutions such as prisons, K-12 schools, colleges, etc. including senior nutrition programs.
- B.** Maximize use of federal programs in the state – e.g., farmers market nutrition programs using incentives for business and marketing campaigns aimed at consumers.
- C.** Increase state support for Iowa local food production, processing, and distribution systems.
- 3. Commission proposal — implement disease management initiatives.**
- A.** Establish a legislative task force (this should be part of the Legislative Interim Commission on Affordable Health Care Plans for Small Businesses and Families if it continues to exist) to review chronic disease management strategies applied in private sector health policies and recommend proposals to expand the use of evidence-based chronic disease management programs throughout the Iowa health insurance market. The task force should:
- Utilize the Department of Public Health Division of Health Promotion and Chronic Disease Management to promote evidence-based disease management strategies in public and private health systems.
 - Develop an agency to provide technical assistance for the implementation of evidence-based disease management strategies, utilizing the most recent research on successful models.

- Task the agency with developing social marketing campaigns to promote disease management strategies with the medical profession, health insurers, and the public.
- Review chronic disease management education provided by professional boards and recommend education resources and curricula that may be integrated into existing and new education programs.
- Extend chronic disease management projects piloted by Medicaid.
- Increase the target disease list from congestive heart failure, diabetes, and asthma to include cancer, hypertension, and stroke.
- Add cognitive disorders and mental health.
- Direct Medicaid to apply for applicable federal waivers.
- Extend chronic disease management strategies to the state's inmate population.
- Require public employment health insurance contracts to include comprehensive chronic disease management and wellness incentives.

4. Commission proposal — advance medical directives planning (end-of-life planning)

A. The Department of Elder Affairs — Legal Service Development and Substitute Decision Making programs — will research end-of-life planning tools that are designed to contain health care costs, in consultation with other agencies and stakeholders, and recommend a public education campaign strategy on end-of-life planning to the General Assembly by January 12, 2009.

B. The Department of Elder Affairs' and the Insurance Division will implement a public education campaign utilizing, in part, CMS' Own Your Future; planning guide for long-term care and tools from the Age and Disability Resource Center in an effort to educate the 50+ population about available and less costly long-term care services (alternatives to facility-based long-term care) that promote health and independence as lowans age.

C. Support the Department of Elder Affairs efforts in a public education campaign about home and community-based services and support efforts to find resources to continue the work of the Age and Disability Resource Center when the Administration on Aging Grant funds expire on September 30, 2008.

D. Encourage physicians and providers to consider the options of providing palliative care sufficient to relieve patients' pain, limited only by patients' informed wishes and the limits of medical science.

E. Encourage health insurance plans, especially state-funded plans, to provide adequate coverage for hospice care.

F. Establish a nonjudicial means (such as mediation) for resolving disputes that may arise in the implementation of advance directives.

G. Ensure that any advance directives accompany an incapacitated individual moved from one health care facility to another (ideally as part of new policies related to use of electronic health records). Amend the Code regarding advance directives to allow for a standardized form that is based on the National POLST Paradigm Initiative. This form would be recognized throughout the health care continuum.

5. Commission proposal — transparency: provide consumers with information regarding cost and quality of health care services to allow better informed decision-making.

A. Eliminate barriers to disclosure of price information. Create mechanisms to allow consumers to be able to compare estimated charges for health care services. This should include not only charges but discount policies given to major payers in Iowa.

B. Work toward health care providers being able to provide consumers with good-faith estimates of the costs of services before services are provided by January 1, 2009. Health plan companies must allow contracted providers to release this information. If a consumer has no

applicable public or private coverage, the health care provider must give the consumer a good-faith estimate of the average allowable reimbursement the provider accepts as payment from private third-party payers for the services specified by the consumer and the estimated amount the noncovered consumer will be required to pay.

C. Facilitate disclosure of quality and patient safety information. Continue to support the efforts of the Iowa Healthcare Collaborative to provide comparative information regarding quality and patient safety in a consumer-friendly, understandable manner.

- Request the Iowa Healthcare Collaborative to include a significant representation of consumers on the IHC Board.
- Request that the Iowa Healthcare Collaborative gather and make available quality and patient safety information on providers (other than hospitals) as it becomes available.

D. Tie any future increase in provider payment under Medicaid to a quality and public reporting standard.

E. Direct providers to develop standard billing practices so consumers know what they are buying.

6. Commission proposal — strengthen the certificate of need process

A. Rename the Health Facilities Council the Health Care Cost Containment Council, broaden its duties and make it a separate division within the Department of Public Health. and add a health economist to the staff of the new Council.

B. Use, to the maximum extent possible, data and information collected independently by the state.

C. Update the program emphasis and criteria to encourage health system development for wellness and health promotion and to improve quality and reduce cost.

D. Require all new hospitals, including replacements within the same county, to complete the certificate of need process.

E. Require all new surgical centers, including those initiated by physician practices, to complete the certificate of need process.

F. Require all new skilled nursing facilities to complete the certificate of need process.

7. Commission proposal — create an office of insurance consumer advocate

- An Office of Insurance Consumer Advocate should be created to investigate the legality of all rates, charges, rules, regulations, and practices of all persons under the jurisdiction of the Insurance Division. The office of the Consumer Advocate on insurance shall:
 - Investigate the legality of all rates, charges, rules, regulations, and practices of all persons under the jurisdiction of the Insurance Division, and institute civil proceedings to correct any illegality on the part of any person.
 - Make recommendations to the General Assembly regarding insurance regulation.
 - Make recommendations to any governmental agency which has an impact on insurance regulation in the state through rulemaking and review.
 - Represent the interests of the public relating to insurance reform, coverage, and rates where action is necessary for the protection of public rights.
 - Provide education and information so consumers understand their insurance policies.

8. Commission a study to determine the costs to achieve the recommendations of the Commission and the potential moneys that might be available through various funding strategies such as general tax revenues; tobacco taxes; premium payments by insureds; maximizing federal dollars; demonstrated cost controls; health insurer assessments (including self-funded plans); assessments of health insurers, hospitals, health providers, and medical equipment; and junk food and other creative assessments.

ATTACHMENT X

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ATTACHMENT XI

**IOWA HEALTH INSURANCE
STATUS SUMMARY**

Iowa Health Insurance Status Summary

Data Sources: Census Bureau CPS 3-year averages; Woods and Poole (2007) Population Projections

(thousands)

Total Population		Below 100% FPL			100% through 133% FPL			134% to below 200% FPL			Below 200% FPL			200% - 400% FPL			400% FPL and above			Total Population				
All Ages		Uninsured		Total	Uninsured		Total	Uninsured		Total	Uninsured		Total	Uninsured		Total	Uninsured		Total	Uninsured		Total		
Year	Number	%		Number	%		Number	%		Number	%		Number	%		Number	%		Number	%		Number	%	
2004	76	27%	281	37	22%	166	60	17%	342	172	22%	789	70	7%	1,052	39	4%	1,064	282	10%	2,905			
2005	76	25%	301	34	22%	156	57	17%	332	167	21%	790	68	7%	1,027	39	4%	1,090	274	9%	2,907			
2006	75	24%	315	31	19%	160	50	15%	333	156	19%	808	75	8%	1,003	40	4%	1,095	271	9%	2,905			
2007	78	24%	323	27	17%	165	46	13%	347	151	18%	836	77	7%	1,034	40	3%	1,131	267	9%	3,001			
2008	82	25%	324	24	15%	165	43	12%	348	149	18%	838	80	8%	1,037	40	3%	1,137	268	9%	3,012			
2009	85	26%	325	21	12%	166	40	12%	349	146	17%	839	83	8%	1,040	40	3%	1,143	269	9%	3,023			
2010	89	27%	325	18	11%	166	38	11%	350	144	17%	840	87	8%	1,043	41	4%	1,151	272	9%	3,034			

Children		Below 100% FPL			100% through 133% FPL			134% to below 200% FPL			Below 200% FPL			200% - 400% FPL			400% FPL and above			Total Children				
Age 00 thru 18		Uninsured		Total	Uninsured		Total	Uninsured		Total	Uninsured		Total	Uninsured		Total	Uninsured		Total	Uninsured		Total		
Year	Number	%		Number	%		Number	%		Number	%		Number	%		Number	%		Number	%		Number	%	
2004	14	15%	92	8	16%	53	15	15%	99	37	15%	244	11	4%	294	4	2%	206	52	7%	745			
2005	14	14%	99	8	15%	52	12	14%	85	33	14%	235	12	4%	289	4	2%	206	50	7%	730			
2006	10	10%	101	6	11%	58	9	9%	93	25	10%	252	14	5%	276	7	3%	202	45	6%	730			
2007	10	10%	98	6	10%	56	6	7%	90	21	9%	245	15	5%	269	8	4%	197	44	6%	711			
2008	9	10%	98	5	8%	56	5	5%	90	19	8%	244	16	6%	268	9	5%	196	44	6%	709			
2009	9	9%	98	4	7%	56	4	4%	90	17	7%	244	18	7%	268	10	5%	196	45	6%	708			
2010	9	9%	98	3	6%	56	3	3%	90	15	6%	244	20	7%	268	12	6%	196	46	6%	708			

Non-Elderly Adults		Below 100% FPL			100% through 133% FPL			134% to below 200% FPL			Below 200% FPL			200% - 400% FPL			400% FPL and above			Total Non-Elderly				
Age 19 thru 64		Uninsured		Total	Uninsured		Total	Uninsured		Total	Uninsured		Total	Uninsured		Total	Uninsured		Total	Uninsured		Total		
Year	Number	%		Number	%		Number	%		Number	%		Number	%		Number	%		Number	%		Number	%	
2004	61	39%	154	29	37%	78	45	27%	167	134	34%	400	59	10%	606	34	4%	763	227	13%	1,768			
2005	62	36%	173	26	37%	72	45	28%	162	133	33%	407	56	9%	601	33	4%	779	222	12%	1,787			
2006	65	35%	186	24	32%	75	41	25%	163	130	31%	424	62	10%	590	31	4%	776	223	12%	1,791			
2007	68	35%	193	22	28%	78	40	24%	169	129	29%	441	62	10%	609	30	4%	800	221	12%	1,849			
2008	72	37%	194	19	25%	78	38	23%	170	129	29%	442	63	10%	612	29	4%	806	222	12%	1,859			
2009	75	39%	194	17	21%	79	36	21%	170	129	29%	443	65	11%	614	28	3%	812	222	12%	1,868			
2010	79	41%	194	14	18%	79	35	20%	170	128	29%	443	67	11%	616	28	3%	818	224	12%	1,877			

Elderly Adults		Below 100% FPL			100% through 133% FPL			134% to below 200% FPL			Below 200% FPL			200% - 400% FPL			400% FPL and above			Total Elderly				
Age 65 thru 80+		Uninsured		Total	Uninsured		Total	Uninsured		Total	Uninsured		Total	Uninsured		Total	Uninsured		Total	Uninsured		Total		
Year	Number	%		Number	%		Number	%		Number	%		Number	%		Number	%		Number	%		Number	%	
2004	1	3%	35	<1	<1%	35	<1	<1%	75	1	1%	145	<1	<1%	153	1	1%	95	3	1%	393			
2005	1	2%	29	<1	<1%	32	<1	<1%	86	1	<1%	147	<1	<1%	137	1	1%	105	2	1%	390			
2006	1	3%	28	<1	<1%	26	<1	<1%	77	1	1%	131	<1	<1%	136	1	1%	117	3	1%	384			
2007	1	2%	32	<1	<1%	30	<1	<1%	88	1	<1%	150	<1	<1%	156	1	1%	134	2	1%	440			
2008	1	2%	32	<1	<1%	30	<1	<1%	88	1	<1%	151	<1	<1%	157	1	1%	135	2	1%	443			
2009	1	2%	33	<1	<1%	31	<1	<1%	89	1	<1%	152	<1	<1%	158	1	1%	136	2	<1%	447			
2010	1	2%	33	<1	<1%	31	<1	<1%	89	1	<1%	153	<1	<1%	159	1	1%	137	2	<1%	449			

Note: 2004-2006 from CPS actual data (3-year averages); 2007-2010 is DHS forecast using Woods & Poole population forecast and CPS data for uninsured trend.

Iowa Health Insurance Status Summary – Non-Elderly Adults Split by Age Groups

Data Sources: Census Bureau CPS 3-year averages; Woods and Poole (2007) Population Projections

(thousands)

Non-Elderly Adults		Below 100% FPL			100% through 133% FPL			134% to below 200% FPL			Below 200% FPL			200% - 400% FPL			400% FPL and above			Total Non-Elderly Adults		
Age 19 thru 64		Uninsured		Total	Uninsured		Total	Uninsured		Total	Uninsured		Total	Uninsured		Total	Uninsured		Total	Uninsured		Total
Year	Number	%	Number		%	Number		%	Number		%	Number		%	Number		%	Number		%	Number	
2004	61	39%	154	29	37%	78	45	27%	167	134	34%	400	59	10%	606	34	4%	763	227	13%	1,768	
2005	62	36%	173	26	37%	72	45	28%	162	133	33%	407	56	9%	601	33	4%	779	222	12%	1,787	
2006	65	35%	186	24	32%	75	41	25%	163	130	31%	424	62	10%	590	31	4%	776	223	12%	1,791	
2007	68	35%	193	22	28%	78	40	24%	169	129	29%	441	62	10%	609	30	4%	800	221	12%	1,849	
2008	72	37%	194	19	25%	78	38	23%	170	129	29%	442	63	10%	612	29	4%	806	222	12%	1,859	
2009	75	39%	194	17	21%	79	36	21%	170	129	29%	443	65	11%	614	28	3%	812	222	12%	1,868	
2010	79	41%	194	14	18%	79	35	20%	170	128	29%	443	67	11%	616	28	3%	818	224	12%	1,877	

Young Adults		Below 100% FPL			100% through 133% FPL			134% to below 200% FPL			Below 200% FPL			200% - 400% FPL			400% FPL and above			Total Young Adults		
Age 19 thru 30		Uninsured		Total	Uninsured		Total	Uninsured		Total	Uninsured		Total	Uninsured		Total	Uninsured		Total	Uninsured		Total
Year	Number	%	Number		%	Number		%	Number		%	Number		%	Number		%	Number		%	Number	
2004	28	40%	69	14	44%	32	19	32%	61	61	38%	162	23	15%	156	12	9%	136	96	21%	454	
2005	29	36%	81	12	37%	33	21	32%	66	63	35%	180	21	13%	164	12	9%	137	96	20%	481	
2006	34	36%	95	12	36%	34	20	30%	67	66	34%	196	25	15%	166	9	7%	129	100	20%	490	
2007	38	38%	99	11	31%	36	21	29%	70	70	34%	206	25	14%	173	8	6%	136	103	20%	515	
2008	42	42%	100	10	28%	36	21	30%	71	73	36%	207	26	15%	175	6	4%	136	106	20%	518	
2009	46	46%	100	9	26%	36	21	30%	70	77	37%	206	28	16%	174	5	3%	136	109	21%	517	
2010	50	51%	99	9	24%	36	22	31%	70	81	39%	204	29	17%	173	4	3%	135	114	22%	512	

Middle Adults		Below 100% FPL			100% through 133% FPL			134% to below 200% FPL			Below 200% FPL			200% - 400% FPL			400% FPL and above			Total Middle Adults		
Age 31 thru 50		Uninsured		Total	Uninsured		Total	Uninsured		Total	Uninsured		Total	Uninsured		Total	Uninsured		Total	Uninsured		Total
Year	Number	%	Number		%	Number		%	Number		%	Number		%	Number		%	Number		%	Number	
2004	24	43%	55	11	34%	33	23	27%	84	57	34%	171	25	8%	322	12	3%	364	95	11%	857	
2005	23	38%	60	11	39%	27	20	28%	72	53	33%	159	23	8%	301	12	3%	364	88	11%	824	
2006	22	36%	61	8	29%	28	16	24%	67	46	30%	155	22	8%	282	15	4%	358	83	10%	795	
2007	21	33%	62	7	24%	28	13	19%	68	40	25%	159	21	7%	288	16	4%	366	76	9%	813	
2008	20	32%	61	5	18%	28	10	15%	67	34	22%	157	19	7%	286	17	5%	363	70	9%	805	
2009	18	30%	61	3	12%	28	7	10%	67	29	18%	156	18	6%	283	18	5%	360	64	8%	799	
2010	17	29%	61	2	7%	28	3	5%	67	23	15%	155	16	6%	283	19	5%	359	58	7%	797	

Older Adults		Below 100% FPL			100% through 133% FPL			134% to below 200% FPL			Below 200% FPL			200% - 400% FPL			400% FPL and above			Total Older Adults		
Age 51 thru 64		Uninsured		Total	Uninsured		Total	Uninsured		Total	Uninsured		Total	Uninsured		Total	Uninsured		Total	Uninsured		Total
Year	Number	%	Number		%	Number		%	Number		%	Number		%	Number		%	Number		%	Number	
2004	9	30%	31	4	28%	13	3	12%	23	16	23%	67	11	8%	128	9	4%	262	36	8%	457	
2005	10	32%	32	4	30%	12	4	16%	24	18	26%	68	11	8%	136	9	3%	277	38	8%	482	
2006	9	29%	31	4	29%	13	5	17%	30	18	24%	74	15	10%	143	8	3%	289	40	8%	506	
2007	9	29%	32	4	28%	14	6	20%	31	19	25%	76	16	11%	147	7	2%	298	43	8%	521	
2008	10	30%	33	4	28%	14	7	23%	32	21	27%	78	18	12%	152	6	2%	307	45	8%	537	
2009	11	31%	34	4	27%	14	9	26%	33	23	29%	81	20	13%	156	6	2%	316	48	9%	552	
2010	11	33%	35	4	27%	15	10	29%	33	25	30%	83	22	13%	160	5	1%	324	51	9%	567	

Note: 2004-2006 from CPS actual data (3-year averages); 2007-2010 is DHS forecast using Woods & Poole population forecast and CPS data for uninsured trend.